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Implementing Coaching to Facilitate the Development of Leadership Competencies Within a Dublin Academic Teaching Hospital (DATHs).

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Royal College of Surgeons in Ireland

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Implementing Coaching to Facilitate the Development of Leadership Competencies Within a Dublin Academic Teaching Hospital (DATHs)

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Abstract

Aim – The aim of this project was to implement coaching into the Hospital’s learning and development leadership academy to assist in the development of leadership competencies for front line managers.

Rationale – Within the Hospital, training and development programmes for line managers have been focused on the delivery of education relating to relevant policies, procedures, guidelines and legislation on managing staff. Evaluation of these programmes had shown that their requirements for future leadership education programmes included support in “leading in challenging times, managing expectations, managing performance and more role-playing to resolve issues.” Therefore there was a requirement to develop a training programme to meet their needs. Coaching is an established method of training that can assist managers in focusing more on the individual, enhancing self-awareness and their interaction with others.

Change Process – The HSE Change Model was used to initiate, plan and implement the objectives set within this change initiative.

Evaluation & Results – Evaluation was conducted using Stufflebeam’s Context, Input, Process, and Product (CIPP) Model and demonstrated that all objectives were met with a very high satisfaction rate from the participants.

Recommendations & Conclusions – The coaching programme has been established as part of the Organisation’s leadership academy to ensure the continued development of leadership competencies for front line managers. Continued funding to support the programme has been secured and the programme is now available to all managers. A coaching governance committee has been established to manage and evaluate the programme going forward.

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List of Abbreviations

CIPP	Context, Input, Process, Product
CLD	Centre for Learning & Development
DOH&C	Department of Health & Children
DATHs	Dublin Academic Teaching Hospital
EMT	Executive Management Team
FEMPI Act	Financial Emergency Measures in the Public Interest Act
FIRO-B	Fundamental Interpersonal Relations Orientation Behaviour
HIQA	Health Information and Quality Authority
HSE	Health Services Executive
HSEland	Health Services Executive Learning Platform
IRFU	Irish Rugby Football Union
ISQSH	Irish Society for Quality & Safety in Healthcare
L&D	Learning & Development
NHS	National Health Service (England)
MBTI	Myers Briggs Type Indicator
NMBI	Nursing & Midwifery Board of Ireland
PESTLE	Political, Economic, Social, Technology, Legal, Environmental
SMART	Strategic, Measurable, Achievable, Realistic, Time bound
SWOT	Strengths, Weaknesses, Opportunities, Threats

1 Introduction

1.1 *Title*

Implementing coaching for front line managers to facilitate the development of leadership competencies within a Dublin Academic Teaching Hospital (DATHs).

1.2 *Aim*

The aim of this project was to introduce coaching into the Hospital's learning and development leadership academy to assist in the development of leadership competencies for front line managers.

1.3 *Objectives*

- 1.3.1** To develop a coaching programme targeted to front line managers by December 2016.
- 1.3.2** To obtain accreditation from an Education Regulatory Body to support the coaching programme by January 2016.
- 1.3.3** To implement the coaching programme for a select group of front line managers by April, 2016.
- 1.3.4** To implement an awareness campaign on coaching in the Hospital by April, 2016.
- 1.3.5** To obtain organisational authority from the mandatory training committee for the coaching programme to be part of the mandatory training requirements for line managers by Quarter 2, 2016.

1.4 Organisational Context

This project was implemented in a large acute teaching Hospital, affiliated to Trinity College the University of Dublin, and part of the Dublin Midland's Group as outlined in the Higgins report (DOH&C, 2013), with a paediatric unit that will form part of the new National Paediatric Hospital (HSE, 2006). This Voluntary Hospital is funded by the Health Service Executive with a budget of €175 million, 615 beds, 3,000 staff and a catchment area of 450,000. The organisation has a Centre for Learning and Development (CLD) which delivers training programmes to both internal and external Health Care Professionals. In 2015 a total of 8,929 Health Care Professionals attended the CLD for conferences, seminars, class room based education and workshops, in educational, professional, or personal development. (Appendix 1).

1.5 Rationale for selecting the project

It is recognised that coaching is a powerful vehicle for increasing performance, achieving results and optimising personal effectiveness (Cox et al, 2014). It is a method of developing an individual's capabilities in order to facilitate the achievement of organisational success (NHS Leadership Academy, 2015). Within the Hospital, training and development programmes for line managers have been focused on the delivery of education relating to relevant policies, procedures, guidelines and legislation on managing staff – i.e. on what you need to know to manage staff. Coaching focuses more on the individual, about becoming more aware of themselves and their interaction with others and can assist managers to improve their performance and develop their leadership skills (Emil Berg & Karlsen, 2012). Coaching is recognised as an excellent tool for raising emotional intelligence as it emphasises self-awareness (Hadikin, 2004).

In 2012 a coaching programme was implemented in seven Ontario Hospitals within the perioperative service (Nigam et al, 2014). This showed that focusing on the role of subjective understandings in shaping to improve efficiency, physicians, nurses and administrators all have

differing frames of the problems that limit efficiency, and proposed through the coaching programme different changes that could enhance efficiency (Nigam et al, 2014). The need for succession planning within the Hospital has been endorsed at executive level (Organisational Redesign Project, 2015). Coaching will assist to prepare new managers for their leadership roles and assist them with their continued development and progression (Gowan, 2011).

1.6 Role of the Student in the Process

The student chaired a project steering committee to implement and govern the project which was sponsored by the Executive Human Resources (HR) Director. Resources and support available to the student within their directorate included a HR Business Partner qualified as a coach and the Head of the Centre for Learning and Development. Following the development of a business case for the project, funding of €4,000 was obtained from one of the Hospital's foundations to support its implementation. The HSE change model was used to manage the project. The HSE change model was developed following a comprehensive literature review undertaken by the Health Policy Unit in Trinity College Dublin – McAuliffe & Vaerenbergh (HSE, 2006). This model recognises that change is a constant feature in the Health Service and that successful organisational change relies on the ability to make people change. It is evident in this model that there is a strong emphasis on the people aspects of change, as well as project management, structure and discipline in the process. The model is based on four stages of the project management lifecycle: Initiation, Planning, Implementation and Mainstreaming (HSE Improving our Services, 2008).

1.7 Organisational impact and expected outcomes

Providing coaching will enhance the learning and development leadership academy within the hospital for developing leadership capability, in particular managing change. Coaching focuses on enhancing self-awareness (Gorringe, 2011). The key component of any change process is the people involved and recognising and investing in building their capacity to engage in any

change process (HSE Guiding change in the Irish Health System, 2006). There is recognition in the value of coaching at a national level, as HSElanD provides the Connect coaching service which is designed to increase capability to support organisational transformation (HSElanD, 2015). This new initiative will become a component of the Organisation's leadership academy. The leadership academy has been developed over the last two years and includes Executive Healthcare Leadership, Foundation Sponsored Fellowships at MSc Leadership Level 9 and a People Managers Programme entitled Introduction to the Roles & Responsibilities of First Time Managers (Appendix 2).

The key expected outcome for line managers who undertake coaching is being a more effective leader by expediting their leadership challenges. This includes:

- Increased confidence and self-belief
- Increased self-awareness
- Increased thinking and analysis skills
- Able to use a goal-centered problem solving approach with own team and colleagues in the workplace
- Improved relationships with others
- Increased awareness of the benefits of a coaching approach

(HSElanD, 2015)

The expected outcomes from the organisation's perspective will be improved efficiencies and performance within the line managers' services. Also, an expected outcome will be an increase in staff retention rates due to positive staff engagement and support from line managers in developing their staff. One of the key objectives of any talent management strategy is to engage staff in conversations about their careers before they look elsewhere (Armstrong & Taylor, 2014). An engaged employee has been defined as someone who feels involved, committed, passionate and empowered and demonstrates those feelings in their work behavior (Mone & London, 2014). Through coaching, assistance can be given to line managers for developing techniques in managing feedback whether positive or negative. It will support the Hospital's objective to

develop succession planning and enhance recruitment for the organisation in becoming an employer of choice.

1.8 Potential threats to implementation

By its very nature, the Irish health sector continuously undergoes change. These changes are necessary to meet the needs of the patient, whether that is through the establishment of new services or the reconfiguration of existing services. The economic, social and political context determines the social well-being of communities and the health needs they express, together with the demands on healthcare organisations (Merson et al., 2012). When considering implementing a change project it is important to understand and define the organisation, its culture, politics, leadership structure and strategy. Understanding an organisation's politics is a key factor in leading successful teams through change. It is proposed that leader political skill represents critical competencies that can contribute in a meaningful way to the effectiveness of teams and their performance (Riggio & Tan, 2014).

For the successful implementation of a change project it is important to identify at planning stage where resistance may come from. Potential resistance should be acknowledged and dealt with. Some of the methods of handling resistance include:

- Effective communication
- Participate decision making
- Negotiation or making deals
- Co-optation and manipulations
- Providing support
- Coercion/applying force of reason

(Sharma, 2008)

Currently within the Hospital performance management does not exist. Notwithstanding that at national level the roll-out of formal performance management programmes was included in the

Croke Park Agreement and the Haddington Road Agreement (LRC 2010-2016); there has been resistance from the unions within this Hospital to engage on a formal programme. Therefore providing coaching to line managers to improve their performance and their staffs' performance required buy-in and cooperation with the unions. Failure to engage with the unions at the planning stage of this project could have resulted in potential non engagement of staff when it came to implementation. The inclusion of staff representatives on the steering committee from the beginning ensured buy in from the unions from the planning stage.

Another potential threat identified was the ability to release staff to attend the coaching training as this is always a challenge in an acute Hospital setting where it is not possible to delay or reschedule work. Combined activity in the Hospital for Adults and Paediatrics on average equates to 76,573 Emergency Department attendances, 24,362 In-Patients, 265,436 Out-Patients, 46,968 Day-ward and a bed occupancy of 95.7% (Hospital Annual Report, 2014). Therefore the inclusion of line managers on the steering committee, allowing them input into how and when the coaching programme should be delivered, addressed this in the planning stage. Also it was anticipated that there may have been resistance from the line managers themselves to attend if the benefits of the programme were not clearly understood and also as this methodology was new to the Hospital. Therefore, key to the success of the project, was the initial classroom based module outlining what coaching is and the benefits both individually to staff and to the organisation in advance of asking the line managers to volunteer to participate in the one-to-one coaching sessions. A presentation was made to the Executive Management Team (EMT) regarding the project to ensure that support was there to release staff to attend. As a training programme for the EMT was in development in 2015 for implementation in 2016, which included coaching as one key element, there was a clear understanding at this level of the aims, objectives and benefits of coaching and that this proposed programme would be a natural fit within the organisation's strategy and culture. This was reinforced by a Hospital wide awareness campaign later on in the project communicating clearly what coaching is.

There are differing theories about where resistance comes from, cited in Burnes (2015) Oreg focuses on resistance coming from individuals whereas Coch and French focus on resistance coming from the organisational context (Burnes, 2015). Notwithstanding where resistance may come from, it needs to be seriously considered during all stages of the change project and can be seen as a dynamic energy that can bring about real and lasting change once it is acted upon appropriately (HSE, 2008). In implementing this project potential threats or resistance were managed through continuous engagement and communication with stakeholders. Another potential threat was securing continued funding for the project and ensuring the project had sustainability. The success and sustainability of the project was proven in the evaluation stage.

1.9 Proposed methods of evaluation

In order to determine the actual training benefits of the coaching programme it is important to evaluate not only short-term outcomes such as reactions at the end of learning but also long term outcomes back at work or transfer to practice (Grohmann et al, 2013). Whilst this project focused initially on the short-term outcomes, it is intended to continue into 2016/2017 to evaluate long term outcomes. It is recognised that the evaluation of long term outcomes can be based on assessment of behaviour change and behaviour ratings as well as organisational results in terms of ratings of service quality and return on investment (Wang & Wilcox, 2006). Stufflebeam's Context Input Process and Product (CIPP) model was used to evaluate the implementation of the change project. The CIPP model was developed in the late 1960's to help improve and achieve accountability for US School Programmes; in particular those aimed at improving teaching and learning in urban and inner city school districts (Stufflebeam, 2003). The four parts of the evaluation process ask: What needs to be done? How should it be done? Is it being done? And did it succeed? (Stufflebeam, 2007). The CIPP approach is based on the belief that the most important purpose of evaluation is not to prove but to improve. It sees evaluation as a tool not to criticise but by which to help make programmes work better for the people they are provided for (Stufflebeam, 2012).

1.10 Requirements for ethical approval

A letter was obtained from the research and ethics committee within the Hospital confirming that ethical approval is not required as there is no clinical element to the project. Any data gathered for the project will be compliant with the 8 principles of the Data Protection Amendment Act 2003 which outlines that data is:

- Fairly and lawfully processed
- Processed for limited purposes
- Adequate, relevant and not excessive
- Accurate
- Not kept for longer than is necessary
- Processed in line with your rights
- Secure
- Not transferred to countries without adequate protection

(Office of the Attorney General, 2003).

The coaches appointed to deliver the coaching programme were qualified to Diploma Level and accredited by the Life & Business Coaching Institute of Ireland (LBCAI). The coaching programme was developed and delivered in line with the organisation's learning and development standard templates and governance requirements. Post-registration category 1 approval was received for the coaching programme from the Nursing and Midwifery Board of Ireland (NMBI) for nursing participants with 7 Continuing Education Units granted. Coaching agreement templates and coaching evaluating templates used by the HSE Connect coaching service were used. One of the recommendations arising from the initiative is the establishment of a coaching governance committee to oversee the continued implementation and further development of the programme. The committee will include links to the national governance framework for coaching within the HSE.

2 Literature Review

2.1 Introduction

A literature review has been defined as identifying a research question and then seeking to answer that question by searching for and analysing relevant literature using a systematic approach (Aveyard, 2014). The review of the literature focused on the benefits for organisations when coaching programmes are introduced for the development of leadership skills for managers. An analysis of the literature brought forward some key themes which will be discussed later. It is recognised that a coaching organisation makes effective use of coaching as a means of promoting both individual development and organisational learning in the service of the organisation's goals and objectives (Hunt & Weintraub, 2006). Executive coaching has become an increasingly common method for skill development which can be seen with the increase in the number of professional coaches (Baron & Morin, 2009). The International Coach Federation which is a non-profit organisation founded in 1995 in the USA now has a membership of over 20,000 with an average growth increase of 500 per month (www.coachfederation.org). The reason most commonly given in the popular literature to explain the ever increasing interest in coaching is the numerous and frequent changes that organisations face have created a need to develop management skills, especially interpersonal skills (Baron & Morin, 2009).

2.2 Search Strategy

For this literature review the following databases were searched by subject headings using MESH 2015 headings or keyword searches as applicable:

- Emerald Insight
- Health Business Elite
- Medline/Pub Med
- Health Management Information Consortium
- Business Source Premier (IMI)

- ABI(Inform)
- Google Scholar

The subject headings or keywords searched were initially coaching, leadership and healthcare. Each search was refined to highlight peer reviewed research articles. As there were a limited number of relevant research articles specifically in healthcare the search was then broadened out to all types of organisations and, where possible, opinion pieces were excluded. There was no year limitation used in the searches as the use of coaching is a relatively new concept that emerged in the 1980's and it is important to see how it has developed over the years. The most relevant literature that emerged was from the USA, Canada and the UK. As themes became apparent such as return on investment and building a coaching culture these terms were added to the key word searches. In total 31 articles were included in the final review, and 6 excluded. A review was also conducted of NHS, UK and HSE documentation relevant to coaching.

2.3 *Review of Themes*

The intention of this literature review is to:

- establish how the use of coaching is beneficial in the development of leadership skills within an organisation and in particular in healthcare.
- explore how coaching can be embedded into the culture of an organisation.
- identify if the outcomes and return on investment of coaching can be measured.

The themes that emerged were - the use of coaching to develop leadership skills, the use of coaching to develop leadership skills in healthcare, coaching and emotional intelligence, the importance of creating a coaching culture and buy in and outcomes and return on investment

2.3.1 Theme 1 – the use of coaching to develop leadership skills

The literature shows that coaching is an integral part of a leadership development programme in any organisation. Organisations should incorporate executive coaching as a natural complement to new or existing training and leadership development programmes (Nyman et al, 2002; McNally & Lukens, 2006; Koonce, 2010). Olivero et al (1997) found that management training alone increased productivity by 22%. However, when executive coaching was used to supplement the training then productivity increased by 88% (Olivero et al, 1997). For leadership to be effective, leaders have to focus on their credibility and legitimacy with followers, development of a relationship by identifying followers' needs and motivations and using resources to draw the best out of followers (Chemers, 2002).

The use of coaching in healthcare to develop leadership skills is slowly gaining momentum with more prevalence in the USA, Canada and more recently in the UK. Whilst coaching is a recognised method of leadership development for leaders in many organisations, it is less so with clinical leaders in healthcare (Budhoo & Spurgeon, 2012). Yet the healthcare industry needs strong executive leadership as the industry is known for constant and rapid change (McAlearney & Scheck, 2008; Conroy, 2011). A study of leadership coaching for physicians and non-medical health care leaders in the USA found that leadership coaching had been an underutilised resource in health care executive training (Henochowicz & Hetherington, 2006). This study was a literature review in which different models of leadership coaching were outlined and examined. It examined physician leadership and non-medical health care leadership in the context of an ever changing and challenging health care working environment. It highlighted that coaching can be utilised at all stages of the medical career, from medical school on to the executive boardroom. It also stated that coaching is an effective and underutilised tool in guiding the health care leader towards mastering competencies and improving emotional intelligence (Henochowicz & Hetherington, 2006). What was evident from this study was that research on the role of leadership is incomplete. It referred to previous research done by Vance and Larson in 2002 where they reviewed 6,628 articles on healthcare and leadership and only 4.4% were quantitative data based the remainder were qualitative (Vance & Larson, 2002).

A later research study of CEOs of U.S. health systems was conducted to study the establishment, organisation, content, process, evaluation, and evolution of Executive Learning Development Programmes (ELDPs). Surveys were used with a response rate of 29% coupled with interviews with 25 leaders including 7 executive level, 7 director level, 7 manager level and 4 non manager level. What emerged was that it was widely used as only 14% of systems did not use coaches, but they had plans to use coaches in future development programmes (McAlearney, 2010). Within the NHS in England a particular model of executive coaching “coaching in context” has been found to be of benefit to clinicians working in Trusts. In facing the challenges of attaining Foundation Trust status, one CEO saw the use of coaching as a leadership development initiative to be a key feature of supporting successful behaviour change. The objectives included coaching and supporting the new executive team during the change, developing the team to embed their roles and focusing clinical directors in line with business needs. A key strength of the study was that there was a measurable outcome to the effectiveness of the coaching programme. The trust achieved recognition at the highest level and delivered the best waiting-time performance in the NHS. The Medical Director who had been part of the initial programme, as a member of the Board, went on to champion the use of coaching in the development of leadership capabilities for senior clinicians. He recognised that this approach was integral to the engagement of clinicians in meeting the changing demands of the NHS. The programme was customised to each individual supported by psychometric tests (MBTI and FIRO-B) and was evaluated using a 360 degree approach through questionnaires and interviews, not only for the clinicians but also their team (Gorringer, 2011).

A further study by Budhoo & Spurgeon in 2012 of clinicians in leadership roles in a healthcare organisation in the UK investigated the views of clinicians on leadership roles and the use of coaching as a developmental tool. The study had both qualitative and quantitative elements and was questionnaire based. There was a 55% response rate from 40 questionnaires. Results regarding the use of coaching highlighted that it was a beneficial tool in developing leadership with a preference for the use of external coaches (to ensure confidentiality) with a healthcare background (Budhoo & Spurgeon, 2012). A blend of internal and external coaches was suggested as being the best solution in a review of a leadership development coaching

programme in a group of three Hospitals with 5,000 staff (McNally & Lukens, 2006). In a London teaching hospital a leadership programme was introduced aimed at specialist trainees who were within a year of gaining a hospital consultant post. The leadership programme initially included three coaching sessions, however following feedback the subsequent programmes that have been run have been increased to four sessions. It was found through participants' feedback that they reported deeper self confidence, heightened self awareness and a greater ability to take control of career choices (Gowan, 2011).

The Irish Health Service has recognised the benefits of coaching for leadership development as it is part of the Co-operation & Working Together (CAWT) Connect Coaching Network. This coaching service was established in 2012 in partnership with the HSE, Health & Social Care, CAWT and the European Union with a the philosophy of belief in individual potential. The aim of the service is to make coaching an integral part of the learning and development strategies for the partnership organisations in order to support staff to be effective in leading change and transformation (HSE, 2012). However this service does not seem to be well publicised or accessed by staff within the voluntary hospital sector and no evidence of evaluation of this service was found.

2.3.2 Theme 2 - coaching and emotional intelligence

Emotional intelligence has been defined as being divided into four skills - self awareness, empathy, self-management and relationship management (Goleman, 2008). In reviewing the literature emotional intelligence is one of the key leadership tools required and coaching is a helpful training process to explore this further and to develop new management behaviour (Emil Berg & Karlsen, 2012). Within healthcare Henochowicz & Hetherington identified that coaching is an effective and underutilised instrument in guiding the health care leader towards mastering competencies and improving emotional intelligence. The recommendation is that coaching should be used at all stages of the medical career, from medical training to executive boardroom (Henochowicz & Hetherington, 2006).

The “coaching in context model” used in the NHS specifically focuses on “the self”, also known as emotional intelligence as one of the four key areas of intervention for the coach with the coachee (Gorringe, 2011). The coach can help the coachee identify patterns of feelings, thoughts and beliefs that may colour their reactions to situations. It can be habits or patterns that may have been useful reference points in the past but which no longer assist in meeting the challenges of the future (Gorringe, 2011).

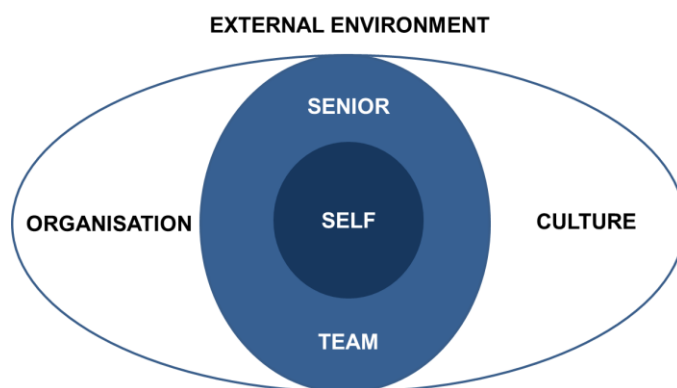


Figure 1 – Coaching in context (Gorringe, 2011)

According to Kombarakarn et al (2008) coaching assists with improving an individual’s performance by increased self awareness and developing new behaviours. In an empirical study by Luthans and Peterson (2003) the effects of executive coaching was measured by changes in the discrepancies between a self-evaluation and evaluations made by others. Following a coaching session to examine the results of 360 feedbacks and a follow up session three months later, the observed differences between the two evaluations tend to disappear (Baron & Morin, 2009).

The concept of the importance of building both human and social capital within organisations to enhance leadership is well established and was the subject of five large leadership studies (McCallum & O’Connell, 2009). This study established that self awareness is a relational competency that is associated with social capital and the use of coaching and mentoring can enhance its development, creating more effective leaders (McCallum & O’Connell, 2009). The development of emotional intelligence by coaching can be supported by the use of psychometric tools such as Myers Briggs Type Indicator (MBTI) as seen in Gowan’s (2011) study of a leadership development programme in a London teaching hospital. The Registrars worked on

using their enhanced self-awareness to good effect in team working, team meetings and interviews (Gowan, 2011).

2.3.3 Theme 3 - the importance of creating a coaching culture and buy-in

The literature identifies the need for participant buy in, organisational support and for coaching to be embedded in the culture of the organisation if it is to be successful in improving performance. It is important that it is championed by the organisation's senior management as a vehicle for strengthening leadership and achieving organisational goals and that it is not perceived solely as a HR initiative but rather as an organisational one (Koonce, 2010). A leadership development needs assessment study was conducted of middle managers employed in a large health authority in Canada with a \$1 billion budget and over 12,000 employees. Whilst the context of this would be smaller than the HSE, it is somewhat comparable to the Hospital Group to which the organisation belongs which had an outturn in 2015 of €792,891 million with a staffing of 9,722 (HSE, 2015). The study established that whilst managers recognised the importance of coaching they also acknowledged that they did use it sufficiently, and in order to build this capacity, a leadership development agenda should include coaching at the individual and organisational levels (Grandy & Holton, 2013). In a study carried out by Baron & Morin (2009) of the impact of executive coaching on self-efficacy related to management soft skills, one finding was that work environment support has a positive relationship with self-efficacy.

The success of a coaching programme in terms of developing leadership competencies and improving performance can be linked to the level of participant buy-in (Bowles et al, 2007). Buy-in has been defined as the active involvement of participants in the coaching process (Peel, 2004). Buy-in can also be achieved by participants when there is confidence in the coaches being used in the programme. A study of the effectiveness of coaching for middle and executive level managers within a large recruitment organisation in the US by Bowles et al (2007) showed a correlation between the successes of the programme with the coaches used. Coaches were chosen with considerable senior leadership experience in recruiting and this experience translated into effective coaching skills which helped to encourage participant buy-in (Bowles et al, 2007). There have been some efforts within the NHS to embed the use of coaching for

clinicians, the future leaders of health care services, early in medical training however it has not yet evolved into widespread practice (Kirkland et al, 2008).

More recent attention has focused on the need for and benefits of creating a coaching culture. Culture has been defined as the multiple aspects of what is shared amongst staff within an organisation such as beliefs, values, behavioural norms and traditions (Parmelli et al, 2011). A literature study of building organisational culture that stimulates creativity and innovation found that the most suited model was based on the open systems theory and the work of Schein (Martins & Terblanche, 2003). Research has confirmed that the rate of change for organisations is accelerating rapidly (Senge, 2014) and therefore creating a coaching culture within an organisation would complement and enhance the ability to achieve a culture of creativity and innovation to support the demand for change. As creating a coaching culture is a lengthy and gradual process it suggests the use of four indicator levels, supported by questionnaires, which can be used to measure progress over time. These levels represent progressive stages on the journey which are nascent, tactical, and strategic and embedded (Megginson & Clutterbuck, 2006).

2.3.4 Theme 4 - Outcomes and Return on Investment

In the USA it is estimated that the annual spend on coaching is roughly \$1 billion (Horn et al, 2010). Yet a study of Executive Leadership Development programmes in the US Health System found that 87% did not evaluate their programmes based on return on investment (McAlearney, 2010). Therefore the focus of the literature review was to identify to what extent outcomes and return on investment are being measured. In a study done for International Coaching Psychology Review, on the basis of their literature search, it estimated that there were probably fewer than 20 robust quantitative outcome studies throughout the coaching literature (de Haan & Duckworth, 2013). Whilst this study found that executive coaching is generally an effective intervention, it recommends the need for a new way of studying executive-coaching outcome in order to improve their services to clients. In studying the literature it was evident that research

in quantifying return on investment for coaching or direct measurement of outcomes only started to emerge in the last twenty years or so. The effect of an executive coaching programme on productivity can be measured (Olivero et al, 1997, Wilson, 2004, Bowles et al, 2007). An action research based study by Olivero et al (1997) was conducted on the impact of a three-day management programme followed by eight weeks of one-to-one coaching sessions for 31 managers in a public sector municipal agency in the United States. It showed that productivity increased by 22% after the three-day programme and by 88% after the coaching programme (Olivero et al, 1997). However as the evaluation was completed immediately following the implementation of the programme there is little evidence of sustainability of increased productivity. A more long term study of the effectiveness of coaching for middle and executive managers was conducted in a US Army recruiting organisation. One of the outcomes measured included coached participants' achievement of their target quotas and personal goals over a 12 month period. The findings showed that coached managers outperformed un-coached, but experienced/incumbent counterparts, supporting the positive influence of coaching on performance (Bowles et al, 2007). A Fortune 500 firm engaged a performance measurement solutions company to determine the business benefits and ROI for an executive coaching programme which showed a 529% return on investment (Wilson, 2004). However the value of this data was based on opinion through survey rather than tangible results.

Research was conducted on a pre-test and post-test study of a leadership development programme using coaching. The objective was to test the capacity of executive coaching to generate outcomes. Data was collected via questionnaires in a large manufacturing company from 73 first and second level managers over an eight month period. The findings showed that the higher the number of coaching sessions attended by managers, the greater the increase in the managers' self-efficacy beliefs (Baron & Morin, 2009). Unless specific measurable research is done following the implementation of coaching programmes it is not always possible to link directly to outcomes or return on investment. A developmental coaching programme for nurses (1,200 staff) was introduced to the Children's Hospital in Boston which is world renowned for its leadership in paediatric care, teaching and research affiliated with Harvard medical school. The initiative was introduced to address a recruitment and retention concerns and the concept was

to train as many nurse managers as developmental coaches in order to improve staff engagement, retain staff and grow the talented next generation. The coaching element was just one of a series of initiatives to achieve its objectives and therefore it was difficult to tease out which components were responsible for certain outcomes (Hunt & Weintraub, 2006).

The research performed on the implementation of the “coaching in context” model in the NHS Trust found that there were identifiable increased quantitative and qualitative changes seen to be achieved for clinicians who had gone through the process. The primary evaluation method was by questionnaire and a significant outcome from the initial process was that the Trust delivered the best waiting time performance in the NHS, meeting nationally set targets two years ahead of target. This intervention is now seen as a long-term study in clinical leadership within the trust where success in the coaching programme can be mapped against the success of the organisation in meeting its challenging objectives (Gorringe, 2011). Notwithstanding that research suggests that there are clear benefits to coaching, it has been suggested that most studies are flawed as solid evidence for effectiveness in predicting organisational performance outcomes is still lacking (De Haan & Duckworth, 2013). In reviewing leadership development in health care in the UK, it is thought that large amounts of NHS money are spent on coaching but that there is little evidence to indicate the return on this investment (West & al, 2015). A suggested alternative approach to measuring ROI is to focus on a well-being and engagement framework rather than financial return. It is proposed that this type of framework can give a richer overview of coaching outcomes and more comprehensive and meaningful metric than financial ROI (Grant, 2012). However, the main weakness of this study is the failure to address how well-being and engagement can be measured in a meaningful way, in particular within the Health Sector where funding is tight and return on investment needs to be tangible in terms of reducing costs.

2.4 Implications for the Project

In reviewing the literature, the benefits of coaching in the development of leadership capability within an organisation is proven, although still a relatively new concept within the health sector

in particular in Ireland. The implications for the project is to ensure that there is a clear understanding within the organisation of the coaching process, the benefits and how it can complement existing leadership development programmes within the leadership academy. The coaching programme's objectives and the expected benefits for the participants should be presented to attendees at the start of the programme (Baron & Morin, 2009). The programme also needs to be championed from the Executive Management Team to encourage buy in from participants and should be supported with an awareness campaign, briefing sessions and explanatory literature. The roll-out of a coaching programme can only be effective if it is implemented in a systematic or formalised way (Grandy & Holton, 2013). This initiative will be just the first stage of establishing a coaching culture within the organisation and therefore ensuring positive feedback from the participants will be essential for its continued viability and financial support. The use of Megginson and Clutterbuck's (2006) questionnaire in the future may be useful in assessing to what extent the organisation is moving to integrate coaching into its processes of performance.

2.8 Summary and Conclusion

In reviewing the literature, notwithstanding the fact that there are limited numbers of robust quantitative outcome studies (de Haan & Duckworth, 2012), the evidence shows the value of incorporating coaching into leadership development programmes within organisations. The literature has emphasised the critical role played by the leader in managing change. The successful management of change is vital to any organisation in order to succeed in a current competitive and continuously evolving environment (Todnem, 2005). Coaching is now a standard component in the organisational toolkit to help employees in their personal development and their contribution to their organisation's success (Kimsey-House et al, 2011). The themes explored in the literature review guided the change agent in the management of project.

3 Organisational Development Process

3.1 Introduction

An organisational development (OD) change model has been described as a process that applies a wide range of behavioural science, knowledge and practices to help organisations build their capability to change (Cummings et al, 2014). The model looks at the effective implementation of the planned change through its processes and leadership. One of the key features of the OD change model is to ensure that there is a transfer of knowledge and the skills used to deliver the change so that the organisation learns from and is better placed to manage change in the future (Cummings et al, 2014). The Health sector by its very nature and composition has been a difficult arena to implement change.

3.2 Critical Review of Approaches to Organisational Development

The output of OD is increased organisational effectiveness. Some of the measures of organisational effectiveness can include increased productivity, increased financial performance and increased employee satisfaction. OD emerged from five major backgrounds or stems as outlined below in Figure 1 (Cummings & Worley, 2014).

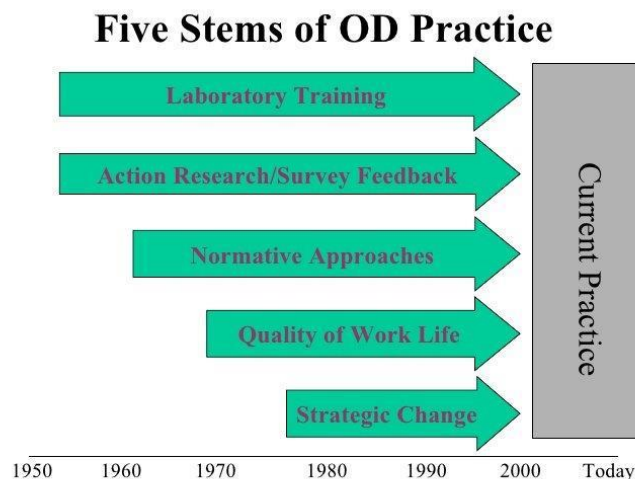


Figure 2 – Five Stems of OD Practice (Cummings & Worley, 2014)

The dominant approach to organisational change over the years has been the OD movement which originated from Lewin's work in the 1930's and 1940's (Burnes & Cooke, 2012). It is widely recognised that Lewin's three major contributions to OD are - planned change comprising of field theory; group dynamics and action research; how psychological theories and techniques used in laboratory experiments can be applied to studying group behaviour; and the need for inclusion and participation in order to address social and organisational conflict (Burnes, 2015.) Lewin's model of OD change is based on three stages - Unfreezing, Moving and Refreezing and whilst some scholars have criticised it for oversimplifying the change process, what remains unchallenged is the model's foundational significance (Cummings et al, 2016). It has also been criticised for its concept of refreezing or cementing the change. The ability to achieve this third phase can be challenging within the context of the increasingly turbulent environment within which many modern organisations operate and the need for continuous change (Senior & Swailes, 2010). Similarly the model has been described as too linear with a view that there is a requirement for a more temporal approach and the emergence of a new dialogic OD which engages the whole system in dialogue (Bartunek et al, 2015). However the use of Lewin's model is evident in the health sector. A review of nursing literature showed the use of Lewin's change theory in administrative and clinical nursing situations. Swansburg and Swansburg (2002) revealed that nurses utilised Lewin's change theory to identify and solve problems (Ziegler, 2005).

Writers in change management developed Lewin's model by expanding the number of stages and some examples of these stepwise models include Lippitt's model and Cumming & Huses' model (McAuliffe & Van Vaerenbergh, 2006). John Kotter expanded on Lewin's model and developed his own 8 step process to transforming an organisation as follows:

1. Establishing a sense of urgency
2. Creating the guiding coalition
3. Developing a vision and strategy
4. Communicating the change
5. Empowering broad-based action

6. Generating short term wins
7. Consolidating gains and producing more changes
8. Anchoring new approaches in the culture

(Kotter, 1996)

Steps one to four of Kotter's model are similar to the "unfreezing" stage in Lewin's, steps five to seven to the "moving" and step eight to the "refreezing". Cameron refers to Kotter saying that it is imperative that good leaders get all the eight steps right and foresees that the process will be a great deal easier if the groundwork is done well (Cameron et al, 2015). A literature review of Kotter's change model 15 years after its introduction found that the model is useful as an implementation planning tool but recommended that complementary tools should be used in the process to adapt to obstacles or challenges (Appelbaum et al, 2012).

Approaches used in change management have also been categorised as hard system models and soft system or "messy" models. With hard system models the emphasis is on quantitative methods of analysis and doing things better. Whereas with soft or messy system models such as OD it is driven by values, underpinned by theory and the overall aim is doing the right thing rather than doing things better. It takes into account the messy nature of organisations' problems which can consist of unclear goals and varying perspectives on what constitutes the problems (Senior & Swailes, 2010). OD is an action research model of change which has been defined as a collective effort across all levels of an organisation using a cyclical process of diagnosing the situation, planning action, taking action and evaluating the action (Coghlan et al, 2001). Senior & Swailes Model (2010) follows a similar six-cyclical process allowing fluidity between each stage as the action impacts on the learning process. The change agent is central to the process and the model focuses on implementing the change by moving from the present state to the future state (Senior & Swailes, 2010).

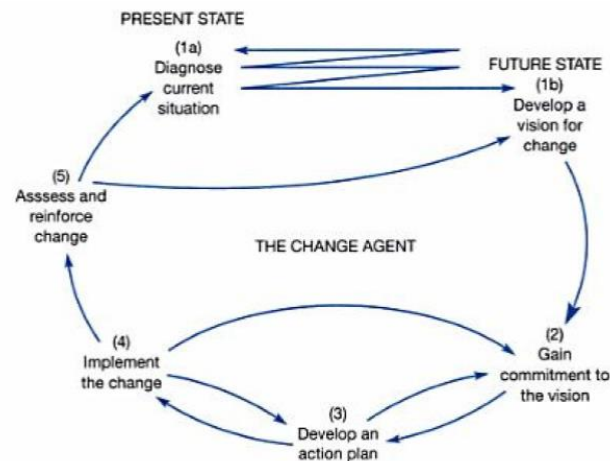


Figure 3 – Organisational Change Model - Senior & Swailes, 2010

3.2.1 Leadership

The literature has emphasised the critical role played by the leader in managing change. The successful management of change is vital to any organisation in order to succeed in a current competitive and continuously evolving environment (Todnem, 2005). An American Management Association survey of 259 senior executives in Fortune 500 companies in the United States in 1994 found that the most frequently mentioned key to successful change is leadership. Other significant elements mentioned were corporate values, communication, teambuilding, education and training (Gill, 2011). As is seen from OD models the change agent or leader is central to the change process. In the NHS in 2006, research by Massey & Williams was conducted with personnel managers who acted as change agents/facilitators running 14 change projects over four Hospitals within an NHS trust over an 18 month period. It found that change agents in healthcare need skills in communicating, relationship development, people management and political acumen whilst retaining their professional integrity (Massey & Williams, 2006). It has been suggested that the importance of ethics within leadership can be often overlooked. There is a requirement to highlight the ethical dimension of change to ensure that leaders and followers act in the interest of many rather than the few (By et al, 2012). More recent attention has focused on the positive relationship between ethical leadership and work engagement where positive

outcomes can be seen in improved employee performance, job satisfaction and organisation commitment (Cheng et al, 2014).

3.2.2 Leadership/Followership and Teams

In order to review how effective leaders facilitate transformation or change it is important to reflect on what an effective leader is (Gill, 2011). The importance of emotional intelligence as discussed previously in 2.4.2 is widely recognised. The literature has emphasised the importance of the development of emotional intelligence competencies in order to successfully run increasingly complex organisations within Healthcare (Henochowicz & Hetherington, 2006). Traditionally it has been argued that people are not born with emotional intelligence but that this skill can be learnt and of the importance of developing a sense of social awareness, self-management, empathy, relationship management and the ability to control emotions (Tuso, 2003). Grandy et al makes the distinction between leader and leadership development where the focus shifts from building individual capacity to relational, interpersonal, social awareness and social skills (Grandy et al, 2013).

Goleman refers to the fact that good leadership maximises its follower's performance. In reviewing leadership in nursing care management it has been said that the relationship between the leader and their followers defines leadership, and how it is an interactive and dynamic relationship with equal importance (Huber, 2013). In implementing a change initiative it is critical to focus on the relationship between the leader and the followers i.e. the team. The NHS Leading with Care model identifies the need to motivate teams and individuals to work effectively. Leading with care and engaging the team are the dimensions that can provide an avenue to motivate and engage staff when implementing change (NHS Leadership Academy, 2013). One of the key factors in implementing this change initiative in an acute Hospital was the establishment of a project steering group or team. It is important to understand the role of each team member and to nurture and care for the team to ensure effective performance. An effective leader recognises what motivates individuals in a team (Borril et al., 2000). The HSE

in their publication Guiding Change in the Healthcare system advocates the establishment of good, working, face to face relationships in functional teams (HSE, 2006).

3.2.3 *Leadership Styles - Transactional/Transformational/Situational*

The differences between leadership and management have been widely debated (Bass & Avolio, 2003; Gill, 2011; Bennis & Goldsmith, 2013). Kotter summarises the differences in that management is planning, budgeting, and organising, staffing, controlling and problem solving and produces predictability and order. Leadership is establishing direction, aligning people, motivating and inspiring and produces change. He goes on to say that the key to successful transformation is 70–90% leadership and only 10-30% management (Kotter, 1996). Similarly, Gill refers to Bernard Bass and Bruce Avolio's Full range Leadership Model: laissez-faire, transactional leadership and transformational leadership. Bass and Avolio describe transformational leaders as those who use one or more of the four I's which consist of individualised consideration, intellectual stimulation, inspirational motivation and idealized influence (Gill, 2011). Whilst transformational and transactional leadership styles are separate they can be complementary (Holten et al, 2015). However to date studies have indicated that transformational leadership is an appropriate style for dealing with organisational change (Eisenbach et al, 1999; Bass & Riggio, 2006).

For change processes to be successful in the Irish Healthcare System, use of transformational leadership is essential. A transformational leader has been defined as a leader who provides a sense of direction, who motivates followers to perform to their full potential and who can influence a change in perception (Huber, 2014). HSE Guiding change in the Irish Health Care System refers to a study done by Carney (1999) about leadership in nursing which found that the transformational leadership style is best suited to nursing as nurse managers are well placed to work in participate co-operation and to empower staff (HSE, 2008). This is also referred to by the NHS Leadership academy which says that the element which most centrally captures the idea of transformational leadership is that of inspirational motivation and the idea of ordinary people achieving extraordinary things through the influence of the leader (NHS Leadership

Academy, 2013). The importance of leadership at all levels within an organisation to effect change is widely recognised (Borrill et al, 2000). A study of nurses' and midwives' clinical leadership development needs reported that in order to provide quality service it is necessary to integrate the clinical leadership role into day to day practice (Casey et al, 2011).

3.3 Rationale for Organisational Model Selected

The Irish health sector, by its very nature, continuously undergoes change to meet the needs of the patient whether that is through the establishment of new services or the reconfiguration of existing services. "The economic, social and political context determines the social well being of communities and the health needs they express, together with the pressures on healthcare organizations" (Merson et al., 2012). The HSE change model was developed in 2008 and recognises that change is a constant feature in the Health Service and that successful organisational change relies on the ability to make people change. It is evident in this model that there is a strong emphasis on the people aspects of change, as well as project management, structure and discipline in the process. (HSE, 2008). It also acknowledges the importance of leadership within change as leading by example is at the centre of its activities for change. It outlines that transformational change needs managers and staff to take their own responsibility to lead and to transform themselves. (HSE, 2008). This model is well recognised and used in the Health Sector which made it well suited to the implementation of the coaching programme. It is supported by a Change Hub Toolkit which provides resources, e-learning programmes and a search facility that links to theoretical and practical models and tools relating to change management, effective leadership, communication and team building.

3.4 HSE Change Model

The HSE Change Model is based on four stages of the project management lifecycle (HSE, 2008):



Figure 4 - HSE Change Model 2008

Although this model outlines four stages it acknowledges that during a change process, all the stages and steps within it, are interrelated and influence each other, and that the process will move back and forth between them. Similar to Senior & Swailes it is cyclical in structure, though it does place an important emphasis on the initiation and planning stage. If this is done correctly it contributes to the successful implementation of the change.

3.4.1 Initiation – Preparing to Lead the Change

The initiation stage of this change project consisted of identifying the need and urgency for the project, development of a business case, stakeholder analysis, identification of leveraging points and risk and issue analysis. The need for the change initiative was already evolving in the Hospital. The organisation had recognised the need for leadership development. In 2015 there were over 100 line manager posts advertised in the Acute Hospital (Recruitment Report, 2015). A Leadership Academy had been developed which included “An introduction to the roles & responsibilities of first time managers”, sponsorship for managers to undertake an MSc in leadership delivered by the RCSI and leadership development at Executive level (Appendix, 2).

Evaluation feedback from the first time managers programme had identified a further training need for the softer skills of managing people and giving feedback whether positive or negative. Coaching, as described by Whitmore, is about unlocking people's potential to maximise their ability, helping them to learn rather than teaching them (Emil Berg & Karlsen, 2012). The literature review supported the concept that coaching is an integral part of leadership development and organisations should incorporate it as a natural complement to new or existing training (Henochowicz & Hetherington, 2005; Koonce, 2010; Gowan, 2011 and Gorringer, 2011). The concept of incorporating coaching as a leadership development tool for line managers emerged and would form part of the development of the leadership academy. This led to the development of a business case which was presented to a foundation associated with the organisation to source initial funding for the project. The business case was then subsequently presented to the Executive Management Team (EMT) for endorsement.

3.4.1.1 Stakeholders/SWOT/PESTLE

Stakeholders were identified using the power grid (Appendix 3). Stakeholders have been defined as those who have a stake in a company's process and or outputs (Lewis, 2011). It is not only important to identify key stakeholders at the start of any change initiative, it is also important to revisit it during the implementation of the project as it may change. The power/influence grid assisted with mapping out who the stakeholders were and how to engage with them. The key stakeholders were not only the line managers themselves that would be undergoing the coaching programme but also the EMT, the Head of the CLD, the HR Team, the Coaches and the Unions. The key players of high power and high influence that were to be managed closely were the coaches and the EMT. With regard to the coaches, for the training programme to be effective it was important that a clear understanding of what was expected in the programme was understood by the managers and delivered by the coaches. Also, as examined in the literature review buy-in by participants can be achieved when there is confidence in the coaches being used (Bowles et al, 2007). The influence and power of the EMT was crucial to ensure engagement with the programme and release of the managers to attend. The line managers themselves were in the high importance/low influence box and the unions in the low importance but high influence as any objections from the unions with regards

to the training programme could affect its implementation and effectiveness. There are tools such as the power interest grid summarised below to assist with mapping out who the stakeholders are and how to engage with them.

A SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) was conducted on identifying leveraging points for the change initiative and this was supported by a PESTLE analysis accounting for the drivers for and against the change (Appendix 4). PESTLE is an acronym for internal or external influences or drivers in an Organisation such as Political, Economical, Social, Technology, Legal and Environmental and it considers the context within which a change is occurring (Gillam et al, 2012). A study on the use of SWOT analysis in health care in the Netherlands found that it should be supported with additional tools such as PESTLE. Strategic analysis in healthcare should be founded on three pillars of stakeholder expectations, resources and contextual developments (van Wijngaarden, 2012). What were identified in terms of strengths and opportunities were the resources and links directly available to the change agent in terms of expertise in developing training programmes, expertise in coaching, direct access to the EMT and to the Foundation for financial support. Positive environmental and political factors included the availability of a state of the art CLD and the use of coaching as a development tool was already established in the HSE with the “connect coaching service”. Potential threats and weaknesses included the non-engagement of staff due to fear or the intimate nature of coaching as a development tool as it had never been used in the organisation previously; and the challenges associated with working in a large acute Hospital and ensuring release time to attend coaching sessions.

3.4.1.2 Culture and Politics

Organisational culture is multifaceted and complicated; it can be encompassed in a variety of forms and is determined by a mix of influencing factors (Wilson, 2001). Understanding the corporate culture within an organisation is essential for leadership to be effective (Gill, 2011). The HSE change model outlines the requirement to understand the political and culture factors

that can have a positive or negative impact on the success of a change initiative (HSE, 2008). Organisations are not only affected internally but also externally by social and economic changes. Similar to other organisations within the Irish Healthcare system the learning & development (L&D) budget had been severely cut due to the financial constraints that had been imposed during the economic downturn with legislation and collective agreements such as FEMPI, Croke Park and Lansdowne Road (HSE, 2010-2016). Investment in staff had been curtailed which had affected the culture and morale within the organisation. However, in the last eighteen months staff has experienced a resurgence of funding and training programmes available as seen in the 2015 L&D Prospectus and therefore it was anticipated that there would be an interest in the introduction of a new coaching programme (L&D Prospectus, 2015). In addition to this an analysis of staffing within the organisation by age shows that 44% of the staff is Generation Y i.e. born between 1978 and 1988 (Appendix 5). Evidence has shown that Generation Y's expectations from their employer place a stronger emphasis on corporate social responsibility and training and development opportunities (Festing & Schafar, 2014). Therefore the coaching programme was very relevant to the expectations of this generation, supporting positive staff engagement which in turn can enhance staff retention. Research worldwide has shown that because there is a shortage of skilled labour, it has become even more important to retain talent within an organisation and that highly engaged staff strengthens the psychological contract between staff and their employer (Ward, 2011). Understanding an organisation's politics is also a key factor in leading successful teams through change. It is proposed that leader political skill represents critical social competencies that can contribute in a meaningful way to the effectiveness of teams and their performance (Riggio et Al, 2014). It was important to ensure that key staff with power and influence capabilities within the organisation were involved in the project steering committee.

3.4.2 Planning

The planning stage, according to the HSE Change model is about building commitment, determining the detail and developing the implementation plan (HSE, 2008). In terms of building commitment for the project it was important to target staff who were already engaged in their

own professional development as leaders within the organisation. Therefore the coaching programme was targeted towards managers who had completed the First Time Managers Programme in 2014 and 2015. Research in the NHS found that one of the strongest drivers of staff engagement is where individuals believe they are being valued and involved (Ellins & Han, 2009). An evaluation project investigating the impact of staff engagement programmes to four NHS Hospital trusts found that some of key success factors were attributed to effective communication throughout the organisation and when championed by the CEO (Hewison et al, 2013). Presenting the business case and project plan to the Executive Management Team was a significant step in building commitment.

3.4.2.1 Resistance to Change

Awareness of potential resistance is also important in the planning stage. Since the emergence of organisational development with Kotter in the 1940's a considerable amount of literature has been published on the nature of resistance to change (RTC). Differing theories exist in the literature. For example: as cited in Burnes (2015) Coch and French focus on resistance coming from the organisational context whereas Oreg focuses on the individual being the main source of resistance which he describes as dispositional resistance (Burnes, 2015). Resistance over the years had been seen as a negative barrier to change. However in more recent times this has altered and an alternative perspective is that it is not always a negative concept as change may not always be inherently beneficial for an organisation (Sharma, 2008). Sharma also refers to Wadell and Sohal (1998) who point out that resistance could show managers that certain aspects are not properly considered in the change process. In planning this project the key factor was to be aware of potential RTC and anticipate where it might come from. It was anticipated that there may have been resistance from the line managers themselves to attend if there was a lack of understanding as to what coaching offered as a leadership development tool, particularly as it was new to the Hospital. Incorporating a classroom based module on "what coaching is" including role playing was planned as part of the programme in order to provide clarity and alleviate any concerns. In a study of the effectiveness of coaching for middle managers within a large recruitment organisation in the USA, it was found that participant buy-in was a key factor for the success of the programme (Bowles et al, 2007). Another area of

resistance anticipated during the planning stage was the ability and commitment from senior managers, particularly in nursing, to release their staff to attend each element of the programme. This is always a challenge in an acute Hospital setting where it is not possible to delay or reschedule work. The addition of the lead Assistant Director of Nursing for Medicine to the project group was to ensure there was a senior nurse manager championing the programme and encouraging release time.

3.4.2.2 *Implementation Plan*

In the development of the project plan it was important to ensure all key stakeholders were involved and therefore a project steering group was set up to plan and implement the project. The planning process of any project consists of providing accurate information, allowing objections to be aired, developing trust, taking organisational culture into consideration and using problem solving approaches. The group which was managed by the change agent, consisted of the Executive HR Director (project sponsor), the Head of the CLD, two staff members who were trained coaches and one of whom was a Senior HR Business Partner, a staff/union representative and as outlined above and the lead Assistant Director of Nursing was added after the first meeting (Appendix 6). This team comprised not only of both staff and senior level grades within the Hospital but also different functions such as Corporate, Nursing, Radiology and Laboratory. Research has shown that the use of cross-functional teams is a positive approach that should be integrated in public sector change programmes (Piercy et al, 2013). In leading the team it was important to be mindful of providing accurate information, allowing objections to be aired, developing trust, taking organisational culture into consideration and using problem solving approaches. Similarly it was important to be mindful of the idea of change through persuasion as required. Garvin et al (2005) proposes that in implementing change you should conduct a four stage persuasion campaign. The business case and information relating to coaching from the HSE connect coaching service website was circulated in advance of the first meeting following which terms of reference were agreed and a project plan developed and actions assigned to team members (Appendix 7). .

3.4.3 Implementation – Implementing the change

The implementation was planned over two phases. The first was to pilot the training programme with the managers who had completed the Introduction to the Roles & Responsibilities of First Time Managers Programme.

3.4.3.1 Training Programme - Pilot

In line with the project plan there were specific actions to be completed for this phase. The line managers were written to asking them to participate in the programme and a copy of the correspondence was sent to their senior managers to ensure release. The content of the classroom based module of the programme was agreed with an experience lecturer and coach and two sessions were scheduled and completed by February, 2016. Members of the project steering group also attended this module to get a full understanding of the programme. External coaches were sourced to supplement the two internal coaches to provide the three one hour session to each manager. This was achieved by establishing links with a local college and partnering with them as part of their practical experience requirements for their students. An application form was submitted to the Nursing & Midwifery Board Institute (NMBI) for accreditation of the programme for nursing participants and approval was received in February, 2016 (Appendix 8). An application form has been completed and sent to the Mandatory Training committee to have the programme recognised as mandatory for all newly appointed line managers. A summary of the number of participants and an analysis of the numbers will be covered in the evaluation chapter.

3.4.3.2 Launch and Awareness campaign

On successful completion of the pilot programme, phase two was to prepare and implement the formal launch of the programme including an awareness campaign. This included the implementation of a communication strategy including supporting literature, presentation to the

EMT, advertising in the organisation's newsletter and culminating in a lunchtime launch open to all the staff (Appendix 9). The launch of the programme was held on the 18th April, 2016 and it included an overview of the coaching programme, feedback from the participants who had completed the programme and a talk from the key note speaker Mr. Stephen Aboud, Head of Technical Direction in the IRFU. A total of 60 managers attended the launch including members of the EMT. When targets are not being met in the implementation phase the HSE model allows for going back to the planning stage to refocus, trouble shoot and re-engage with stakeholders. This was required in order to ensure release and encourage line managers to participate and further communication was sent to the EMT updating them on progress and to encourage them to release staff to attend the second module, the one-to-one coaching sessions. Line managers were contacted individually to encourage them to contact their allocated coach in order to complete the programme.

3.4.4 Mainstreaming

During the mainstreaming not only is there a focus on the success of the initiative but also to ensure there is integration into normal hospital business and continuous evaluation and learning (HSE, 2008). The main focus of the mainstreaming phase was to ensure that the coaching programme became a component of training under the leadership academy and included in the L&D prospectus. This was achieved by including it as a second component of the first time manager's programme (increasing the programme from two to three days) and by making it compulsory for first time managers when appointed to have completed the full programme within the first year of appointment. This was supported by applying for approval from the Mandatory Training Committee to have it included in its policy. The importance of creating a coaching culture in order to drive performance improvement within an organisation was outlined in the literature review. Creating and measuring coaching culture had been defined into four levels – Nascent, Tactical, Strategic and Embedded (Megginson & Clutterbuck, 2005). The organisation is now at the early phase of the tactical level where it recognises the value of establishing a coaching culture but will need to build on this in order to move it into the strategic and embedded levels. The project came well within the €4,000 budget with only €800 spent. The final element

of the mainstreaming phase of the HSE model is on reviewing the effectiveness of the change process and forming the basis for continuous improvement which will be covered in the evaluation chapter.

3.5 Summary and Conclusion

There is a vast array of literature on managing change available. The Irish health care system has endured some radical changes, particularly in the last six years with the implementation of the Croke Park and Haddington Road agreements (LRC, 2010 – 2016). These agreements have demanded change with an increase in working hours bringing about changes in rosters and the implementation of the extended working day. The learnings from implementing these changes in a large acute Hospital are that it is dependent on strong leadership. It requires bringing people with the organisation by sharing a vision, clarity of information, effective planning and constant communication and engagement. The approach adopted in the development of the HSE Change Model included a comprehensive literature review and is best suited to use as model for change in Irish healthcare. It advocates that it particularly focuses on the many groups who need to play their part in contributing to change including staff, teams, patients, services users and representative organisations (HSE Improving our services, 2008). The implementation of this coaching programme in itself is investing in staff and building their capability to adapt to change and therefore improving the organisation's performance in the delivery of quality health care to patients.

4 Evaluation

4.1 Introduction

Quality improvement is a process that should be a significant part of everything that we do (Tagues, 2005). Evaluation has been described as a systematic approach to collect and analyse data in order to reach a judgement on whether something has merit or worth (Smith et al, 2012). This chapter will outline the importance of evaluating change projects within a healthcare setting, the evaluation model used and the results of the project in the context of the objectives that were set.

4.2 The Significance of Healthcare evaluation

The focus in healthcare has been on improving the quality of patient care and the method of evaluation that has had a significant influence on clinical practice over the last few decades is evidence based medicine (Sackett, 1996). A review of evidence based healthcare and quality improvements has shown that for quality improvement initiatives to be effective they should be based on sound evidence of benefit through evaluation. The evidence of benefit should lead to improvement in patient outcomes that are clinically important and cost effective and evidence to reflect what works to implement those products or approaches (Gillam et al, 2014). It is recognised that evidence-based decision making is essential in informing policy in global health interventions and programmes (Luoto et al, 2013). The World Health Organisation advocates that monitoring and evaluation are essential for public health (WHO, 2015). Within the national context increased demands for value for money in public services such as the HSE have resulted in a stronger emphasis on accountability and quality (LRC 2010-2016). Evaluation has evolved dramatically and is no longer mainly concerned with measurable outcomes but also with stakeholder roles, values and quality, (McNamara et al, 2010).

There is a comprehensive national framework including regulatory bodies aimed at improving the delivery of quality healthcare such as the Health Information and Quality Authority (HIQA) and the Irish Society for Quality and Safety in Healthcare (ISQSH). These developments reflect an acknowledgement of the importance of maximising patient satisfaction, reducing preventable adverse incidents, enhancing professional fulfilment for staff and using healthcare resources efficiently (Department of Health, 2013). HIQA is an independent authority that was established under Section 8(1) b of the Health Act 2007 to set standards in health care, monitor quality and safety and support continuous improvements (HSE, 2007). HIQA reports to the Minister for Health and the Health Service Executive (HSE). In 2012 they published The National Standards for Safer Better Health. These standards set the framework and provide a roadmap for improving the quality, safety and reliability for healthcare; each Hospital is required, using the self assessment tool, to measure their compliance and identify and prioritise areas for improvement (HIQA, 2012). The quality improvements required result in actions being identified at Hospital level which require changes to improve the service. Evaluation of these change initiatives needed to focus not only on the outcome but also the process involved. It is an accreditation process that will lead to the future licensing of Hospitals and health care providers

4.3 Evaluation

The aim of this project was to introduce coaching into the Hospital's learning and development leadership academy to assist in the development of leadership competencies for front line managers.

4.3.1 Evaluation Models

The use of evaluation models had become more attractive over time as they allow for the evaluation of the intended and unintended effects of a change project (Linzone & Schiuma, 2015). In a review of programme and project evaluation models using a systematic literature review approach, it emphasised the importance of choosing a suitable evaluation model to ensure an effective and efficient evaluation process (Linzone & Schiuma, 2015). A study

conducted by Frye & Hammer (2012) looked at the theories of science that have influenced the development of common educational evaluation models with the most suitable being Kirkpatrick, the Logic Model and CIPP. It recommended when designing educational programmes to choose from these individual models or a combination of them to develop an appropriate evaluation model (Frye & Hammer, 2012).

Kirkpatrick's four-level evaluation model was first published by Donald Kirkpatrick in 1959 and later updated in 1975 and 1994. It is still widely used for evaluating training and development programmes and is a results or goal-based evaluation as outlined in Figure 5 below

Level 1	Reaction	What participants felt about the project or programme
Level 2	Learning	Internal Validation – were the objectives met
Level 3	Behaviour	External Validation - has training transfer taken place
Level 4	Results	Has the programme made a difference

Figure 5 – Kirkpatrick's four-level model of evaluation (Kirkpatrick, 1996)

Although consideration was given to using this evaluation model for the project it has been criticised for being too linear in approach and does not take into account intervening variables that can affect learning (Frye & Hemmer, 2012; Passmore & Velez, 2012). It has also been criticised for the causal relations between the levels of evaluation which implies that it is not possible to achieve positive results at top levels if this does not occur at the lower levels (Guerci et al, 2010). Training programmes are inherently about change, changing learner's knowledge or skills and therefore can be complex to evaluate (Frye & Hemmer, 2012). Therefore the linear approach as defined in Kirkpatrick model was considered too limiting and a more cyclical model was considered.

4.3.2 Method - CIPP Model

Stufflebeam's Context Input Process and Product (CIPP) model was used in evaluating the initiative as previous studies have highlighted its suitability for evaluating training and development programmes (Galvin, 1983; Zhang et al 2011, Hakan & Serval, 2011; Frye & Hammer, 2012). The CIPP model is flexible and allows for evaluation before during and after the process. It facilitates evaluation by evaluators and stakeholders at the beginning (context and input) whilst in progress (input and process) and at its end (product) or before, during and after the process (Zhang et al 2011; Hakan & Seval, 2011). Context evaluation has been referred to as the needs assessment and looks at defining problems and opportunities within the organisation setting and environmental context (Stufflebeam & Shrinkfield, 2007). Input evaluation addresses the identified needs, current system capabilities asking "How should it be done" (Zhang et al). Process evaluation assesses the project implementation and highlights any potential barriers which in turn identify needs for process adjustment (Frye & Hammer, 2012). Product evaluation focuses on outcomes and looks at meeting the stakeholder needs and looking at the future needs of the organisation (Hakan & Seval, 2011).

4.3.3 Results

4.3.3.1 Context – What should be done?

Evaluating the context was to look at the organisation's needs and the individual needs of the line managers to whom the coaching programme was being delivered. An introduction to the Roles & Responsibilities of First Time Managers Programme had been delivered in the organisation in 2014 and 2015. Evaluation of these programmes had shown that attendees were keen to have more training and highlighted under "are their topics you would like to be covered at future leadership education programmes?" were requirements such as "leading in challenges times", "managing expectations", "managing poor performance", "more role playing to resolve issues" and "coaching". This was also supported by the literature review which showed that the use of coaching in healthcare to develop leadership skills had been underutilised in the past but was gaining momentum (Henochowicz & Hetherington, 2005). As

a consequence, these two groups of line managers were selected to pilot the coaching programme. Another consistent element from the evaluation was “every manager should do this course within months of appointment”, “it should be mandatory”. It was on this basis that the following objective was set:

“To obtain organisational authority from the mandatory training committee for the coaching programme to be part of the mandatory training requirements for line managers by Quarter 2, 2016”

Approval has being sought to firstly extend the Introduction to the Roles & Responsibilities of First Time Managers Training Programme from two to three days to include the coaching programme and, secondly to make it mandatory for all newly appointed line managers to complete the programme within six months of appointment (Appendix 10). In terms of evaluating the context it was important that there was buy-in from the organisation to support the delivery of the programme. The literature review had highlighted the benefits where coaching programmes are championed by senior management and not solely owned within HR (Koonce, 2010). Therefore, establishing key stakeholders to sit on the project steering group, including an Executive team member and Assistant Director of Nursing, was important, as well as presenting to the Executive Management Team in advance of the programme commencing.

4.3.3.2 *Inputs – How should it be done*

In terms of evaluating how the programme was to be delivered the steering committee looked at established and relevant resources, both internal and external, to the organisation. These included excellent training facilities in the organisation’s CLD and established links with academic partners. An experienced lecturer from the RCSI, and trained coach, delivered the two half-day classroom modules on “An introduction to coaching” and the training was held on site in the CLD. The ability to deliver the training on site with excellent audio visual supports ensured the delivery of the programme would be professional as well as facilitating easy access and minimal disruption to services for the line managers attending. A programme syllabus was

agreed in line with the organisation's template (Appendix 11) which met the project's first objective:

"To develop a coaching programme targeted to front line managers by December 2016".

The content of the programme also needed to meet the criteria set by the regulatory body the Nursing and Midwifery Board of Ireland (NMBI), in order to meet the project's second objective which was:

"To obtain accreditation from an Education Regulatory Body to support the coaching programme by January 2016".

Post-registration category 1 approval was received for the coaching programme from the NMBI for nursing participants for two years from the 23rd February, 2016 to the 23rd February, 2018 with Continuing Education Units granted at 7 units. (Appendix 8). The criteria used by the NMBNI to evaluate training programmes included programme rationale, aims and objectives, indicative syllabus and content, facilities, methodology and assessment.

In the literature review a study on a coaching programme in the health service in the UK had shown that there was an increase trust in independence and confidentiality when external coaches were used (Budhoo & Spurgeon, 2012). A study in the US of Leadership Development Coaching Programme for a Multicare Health System of three Hospitals and 5,000 staff found that a blend of internal and external coaches can be the best solution (McNally & Lukens, 2006). Whilst there were two trained coaches available within the organisation it was decided to [link](#) also with an external source. The Coaching and Mentoring Partnership (TCMP) deliver an Executive and Leadership Coaching Diploma which [is](#) accredited by the Life & Business Coaching Institute of Ireland (LBCAI) and recognised by the Association for Coaching, a leading international non-profit professional body for coaching (TCMP, 2016). A requirement in achieving the Diploma with TCMP was to undertake [30](#) coaching [hours](#) during the final [4](#) months of their programme. Following discussions with the provider and a review of the previous role profiles of the graduates of 2015-2016, three students coached some of the participants.

4.3.3.3 Process – it is being done as planned?

Evaluation of the process involved constant monitoring of the project, how well it is being implemented and identifying any potential barriers or adjustments required. The project steering committee monitored the implementation of the project and when the uptake amongst the targeted line managers for the coaching programme was slow, both the line managers and their senior managers were contacted directly by the project steering group to encourage participation. Members of the project steering committee also attended Module 1 in order to get a clear understanding of the course content and also show support for the programme. This was well received from the participants and evidenced in their feedback outlined later in this chapter. Below is a table outlining levels of participation in the programme and whilst it may seem low that only 50% of those invited to attend did so, this was anticipated based on previous experience of training programmes run in the organisation. In terms of capacity 12 – 15 was the target figure with the allocation of coaches available. Training programmes delivered in an acute Hospital setting are always overbooked on the basis that there may be difficulty in releasing staff on the day due to service demands.

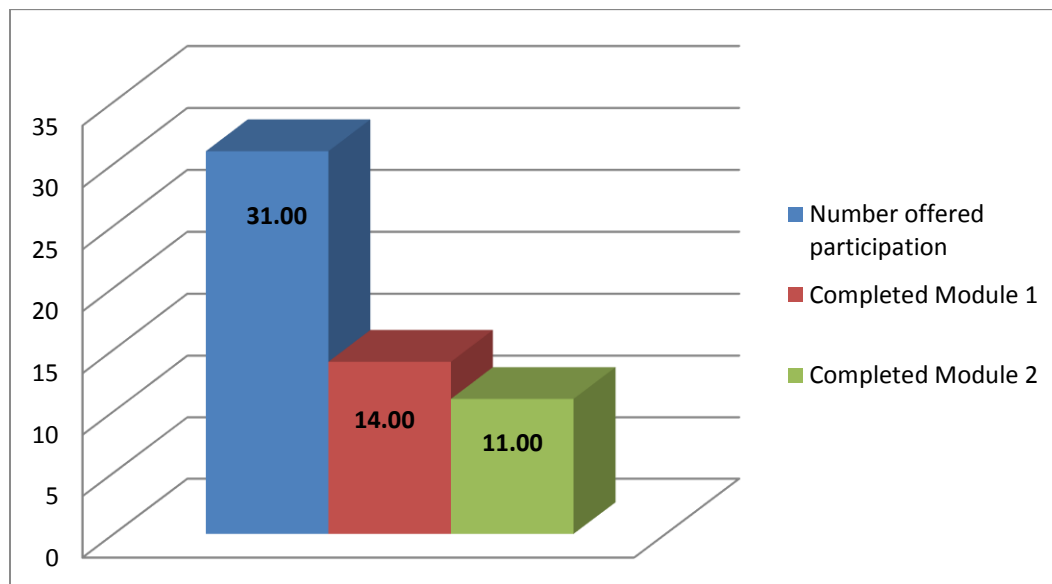


Table 1 – Attendance Figures

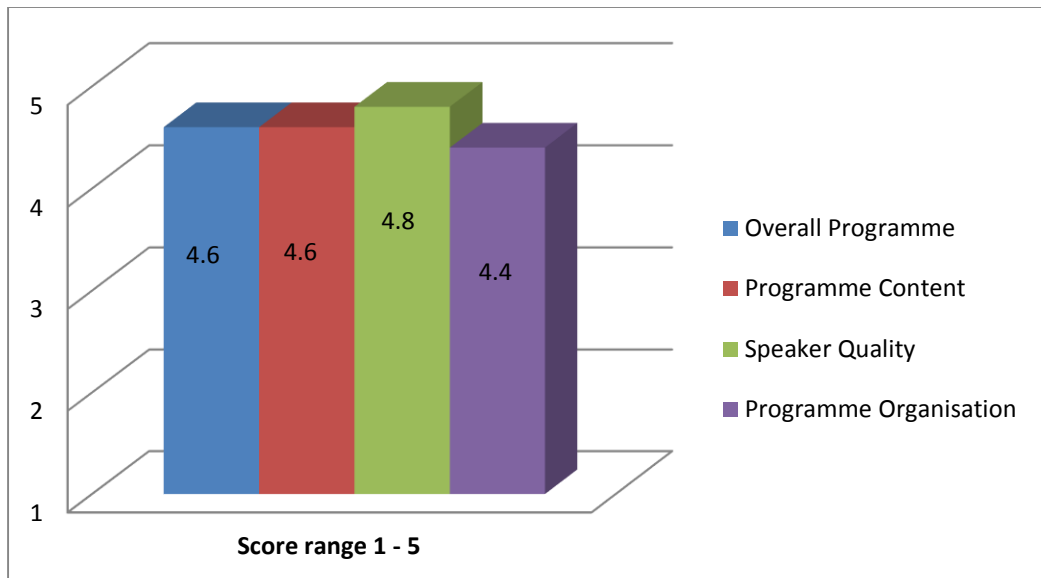


Table 2 – Evaluation of Module 1 of Coaching Programme

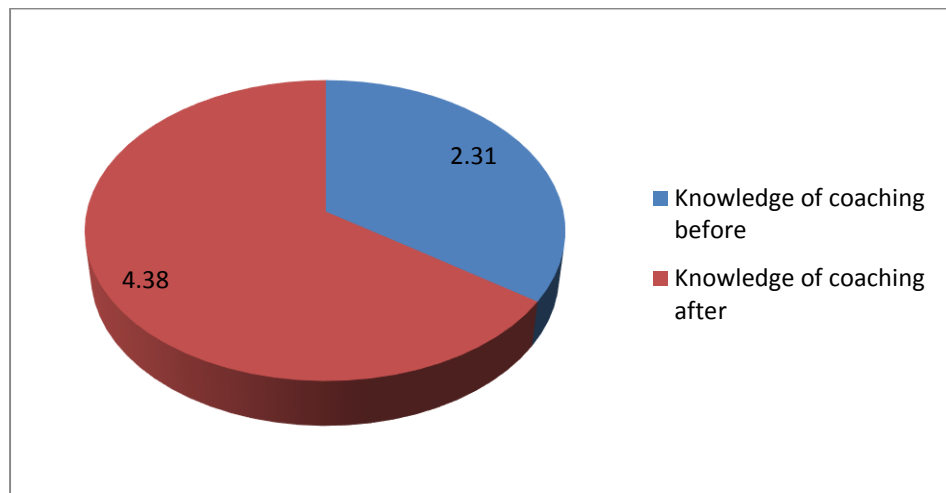


Table 3 – Evaluation of knowledge of coaching post Module 1

The classroom based module 1 of the programme was evaluated after each session using the organisation's established training programme evaluation sheet with a rating score of 1-5 based on the following criteria: "overall programme, programme content, speaker quality, programme organisation" and an additional criteria was added of "knowledge of coaching before and after

attending the programme”. This criterion was added to ensure that the participants understood coaching before moving onto phase 2 of the programme which was the individual sessions with an appointed coach. This evaluation showed a very high satisfaction rating with the programme being delivered and in particular the facilitator, with a recommendation for information on coaching to be provided in advance of the training.

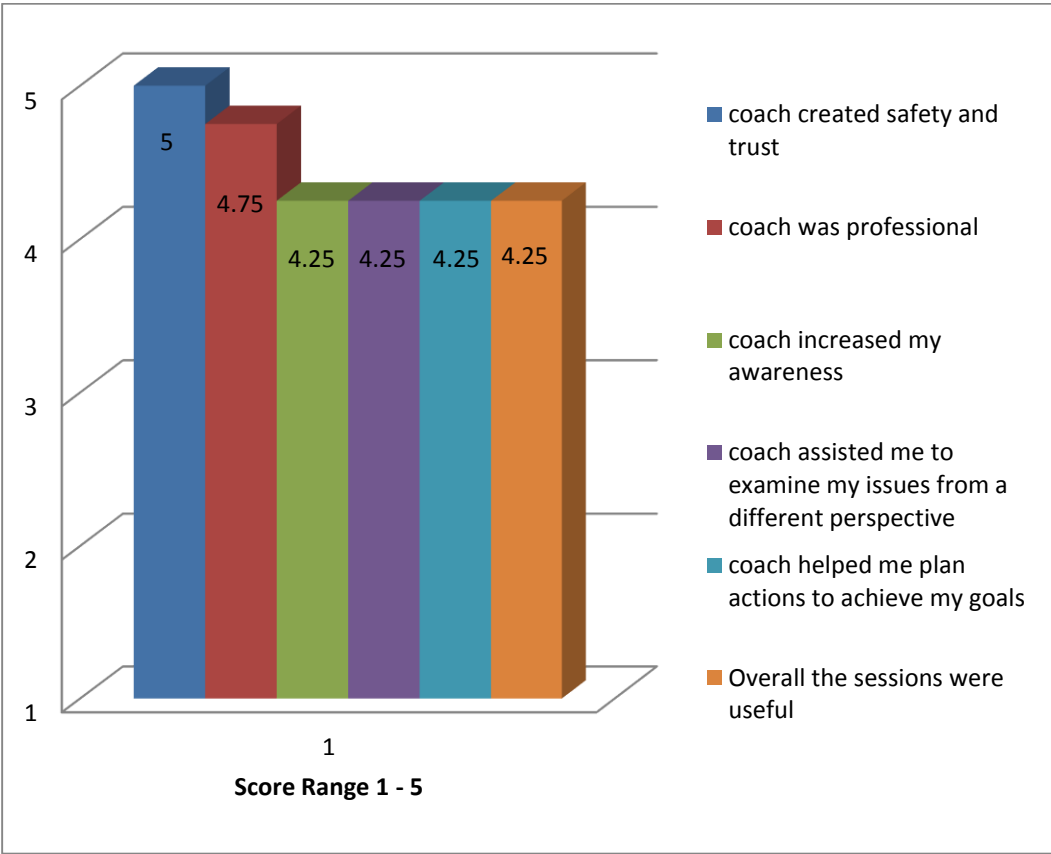


Table 4 – Evaluation of Module 2 – Individual coaching sessions

Phase 2 of the coaching programme was assigning coaches to the line managers to deliver three x one hour individual coaching sessions. 11 managers have participated in phase 2 of the programme to date, meeting the project’s fourth objective:

“To implement the coaching programme for a select group of front line managers by April, 2016.”

An evaluation of these individual coaching sessions using the HSE’s Connect Coaching service evaluation form (Appendix 12) has shown a very high level of satisfaction with this element of

the programme. The evaluation used a rating of 1-5 based on the criteria outlined in Figure 10 which demonstrated that the coaches established an excellent rate of trust with the managers and that there was a very high satisfaction rate with the coaching processes itself, including agreed outputs.

An awareness campaign was planned for April 2016 to launch the coaching programme and open it to the whole organisation as the initial project has piloted the programme with the selected group of line managers. This met the fifth objective set which was to:

“To implement an awareness campaign on coaching in the Hospital by April, 2016”.

The launch was part of the communication plan within the change process and was aimed not only at creating awareness of the programme but also communicating the emerging vision and the business case for the change in an engaging style (HSE, 2008). It was held in the smaller of the two lecture theatres in the CLD to create a cosier atmosphere. In order to maximise attendance for the launch all line managers and the senior executive team received an individual invite as well as e-mail reminders and the event was publicised in the organisation’s fortnightly newsletter in advance. An information booklet was designed to support the launch, an intranet page was created within the HR Directorate site specifically for the coaching programme and an application form and e-mail address was created for any line manager to apply to participate in the programme. The launch has been recognised as one of the best attended in the organisation with 60 managers attending including Senior Executives. The guest speaker Mr. Stephen Aboud, Director of Coaching for the Irish Rugby Football Union, delivered a very well received insight into how coaches have to engage with their team in order to be effective, similar to managers engaging with their staff in the delivery of their service.

4.3.3.4 *Product - Did the programme work?*

This phase of the CIPP model measures the project outcomes and evaluates if it will meet current and future needs (Hakan & Seval, 2011). In particular the focus is on reviewing the extent to which the needs of all the participants are met (Zhang et al, 2011). Looking at the

data gathered to date during evaluation, it is clear that the needs of the line managers were met in terms of the content and delivery of the programme. In looking at future needs for both participants and the organisation, as advised previously the coaching programme will now be incorporated into an extended first time line managers training programme. The programme will also be made available to all other line managers through an on-line application process. €3,200 of the original budget of €4,000 still remains and will be allocated to develop further literature, psychometric tests and for external coaching resources as required. It has been agreed that this coaching programme going forward will be resourced from within the training & development budget and it will be recognised as part of the leadership academy within the L&D prospectus for 2016/2017. The use of psychometric testing to support coaching programmes was evidenced in the literature review (Gowan, 2011; Gorringer, 2011), however due to time and resources constraints it was decided not to use it for the initial project. Consideration is now being given by the organisation to resource and supplement the programme with psychometric testing in advance of the one-to-one coaching sessions.

4.3.4 Dissemination Plan

As advised previously, the coaching programme has already been formally launched within the organisation with supporting documentation, intranet page and e-mail address for referrals. This information will now be available in advance to new participants undertaking the programme which was a suggested improvement identified by the participants in their evaluation forms. Presentations on the successful completion of the project and its place within this learning organisation are scheduled to be made to the EMT and the Organisational Development sub-committee of the Hospital Board. The programme, including on-going evaluation, will be presented to the Annual Quality Improvement Clinical Audit Day in 2017. An application form outlining the details of this initiative has been submitted to Health Management Institute for consideration for their Annual Awards. It will also be made available on RCSI epublications.

4.4 *Summary & Conclusion*

The aim of this initiative was to implement coaching into the Hospital's learning and development Leadership Academy to assist in the development of leadership competencies for front line managers and this was achieved. All five objectives were met as outlined above. The evaluation model chosen is widely recognised in the literature as being suitable for education programmes (Sing, 2004; Zhang et al, 2011; Hakan & Seval, 2011; Frye & Hemmer, 2012). The evaluation model complements the change model used for the project in terms of its flexibility to go back and forth between each phase/stage allowing adjustments to be made as required. The CIPP components accommodate the ever-changing nature and all phases of an educational programme (Frye & Hemmer, 2012). Conducting an evaluation of an education programme will address accountability requirements, information for planning and guiding the delivery of the programme (Sing, 2014). Through evaluation the viability of the project has been proven and recommendations have been made in Chapter 5 to meet the future needs of the organisation and the participants.

5 Discussion & Conclusion

5.1 *Introduction*

There are a myriad of contributions in the literature outlining how organisational change is challenging and notoriously complex with a high rate of failure (Jacobs et al, 2013). However, change is a constant feature in the Health Service and successful organisational change relies on the ability to make people change and good project management with structure and discipline in the change process (HSE Improving our Services, 2008). Any change implemented within an organisation should include a review on how the initiative impacted on structure, processes, people and culture. This chapter will review project impact, outline strengths and limitations and make recommendations for the organisation for the future.

5.2 *Project Impact*

The aim of the project was to implement coaching into the Hospital's leadership academy to assist in the development of leadership competencies for front line managers. The literature review explored relevant themes and the key emerging theme was that coaching is an integral part of a leadership development programme in any organisation (Nyman et al, 2002; McNally & Lukens, 2006; Koonce, 2010). The impact of the project, in particular through the Hospital wide launch of the programme, has been in instilling awareness amongst staff of the value of coaching in the development of their leadership skills. The focus of the coaching programme has been on unlocking potential. The programme is entitled "SOAR Coaching Programme for People Managers" using the acronym SOAR for Self Awareness, Ownership, Action Results as well as referring to the quotation from A.D. Posey – "Believe in people, they fly for a day. Teach them to believe in themselves they SOAR for a lifetime". A patent is currently being sought for the use of the word SOAR for the coaching programme by application to the Irish Patents Office.

Evidence shows how coaching assists with improving an individual's performance by increased self awareness and developing new behaviours (Kombarakaran et al, 2008). Access to coaching is now available to all line managers and is a natural addition to the leadership academy that has been developed in the organisation over the last two years. The leadership academy was established to create a pathway to developing better leaders, to deliver improved care and included targeted development for all levels and experiences (Leadership Academy Business Case, 2015). This initiative complemented the established learning and development (L&D) culture within this Academic Teaching Hospital. The L&D strategy supports education that underpins the service delivery operating model by utilising a variety of learning methodologies and continuously updating and improving the quality and accessibility of education and training (CLD Annual Report, 2015).

5.2.1 Stakeholders

Stakeholders have been defined as powerful individuals and groups with an interest in the change that can support or thwart the process (Cummings & Worley, 2014). As outlined in Chapter 3, it was important to map out key stakeholders and influencers and engage with them formally and informally to assist with establishing any opportunities or possible concerns (HSE, 2008). The Stakeholder Analysis Grid in Appendix 3 showed that the key players of high power and high influence that were to be managed closely were the coaches and the Executive Management Team (EMT). Presentations to, and individual discussions with, the EMT throughout the planning and implementation of the change initiative ensured support for the programme and release for the participants to attend. Having some of the coaches on the project steering committee provided expertise in the planning and implementation of the programme, and also allowed for the scheduling of the one-to-one coaching sessions to be increased as required in order to meet timelines that had been set. In terms of achieving buy-in from current and future participants of the programme it was important that each line manager had at least commenced the one-to-one sessions if not completed them by the time of the launch on the 18th April, 2016.

5.2.2 *Practice*

Following the launch of the coaching programme, the L&D prospectus has been updated to reflect this progressive addition. A brochure has been designed for the programme outlining what coaching is, the process involved, outcomes for participants, outcomes for the Hospital and the organisational aim of developing a coaching culture. The programme whilst initially piloted to participants of the First Time Managers Programme, is now accessible to all managers. A web page has been created on the Human Resources and Centre for Learning & Development intranet sites including the brochure, FAQ Document and an application form to apply for coaching. A dedicated e-mail address has been set up for enquires and applications.

5.2.3 *Theory*

The literature review established and then explored the following themes which helped identify important aspects in implementing the change:

- The use of coaching to develop leadership skills/ and in particular within health care
- Coaching and emotional intelligence
- The importance of creating a coaching culture and buy-in
- Outcomes and Return on Investment

In particular, as coaching is a relatively new concept in the health sector in Ireland and to the organisation, engaging the stakeholders, presenting a clear understanding of the coaching process and its benefits and taking every opportunity and using every communication forum to promote the programme was critical to success. Kotter (2007) when looking at why transformation efforts fail, refers to the error of under communicating the vision by a factor of ten which emphasised the importance of having a comprehensive communication strategy throughout the change process. The communication strategy implemented included presentations to the Executive Management Team and Organisational & Development Sub-Committee of the Board, an article in the organisation's fortnightly newsletter, direct mail shots to line managers, designing a programme brochure, intranet page, dedicated e-mail address

and culminating in a formal lunch time launch. The change model used emphasised the people aspects of change, as well as project management, structure and discipline in the process (HSE, 2008). Critical to success and in line with characteristics of OD which encourages team work was to have the key stakeholders involved from the initiation stage and support at all levels across the organisation. OD is an action research model of change following a cyclical process (Coghlan et al, 2001). Both the change model and evaluation models used complemented this cyclical approach to change. Although the models have defined stages within them it is acknowledged that during a change process, all the stages and steps within, are interrelated and influence each other, and that the process will move back and forth between them (HSE, 2008).

5.3 Strengths of the Project

One of the strengths of the project is that the organisation was a learning organisation with an established training and development culture, delivering a comprehensive prospectus supported by state of the art facilities. In terms of meeting one of the objectives which was to obtain accreditation from an Education Regulatory Body to support the coaching programme, there was experience and expertise within the project steering group in completing the application form to achieve this. Another strength was that the change agent's role within the organisation gave them direct access to and an established relationship with the key stakeholders such as the EMT, Head of the CLD, Unions, Line Managers and internal coaches. Effective leadership of change emphasises the importance of the development of social capital which develops the ability to form and maintain networked relationships (Grandy & Holton, 2013). Access to funding to support the project through the established relationship between the Hospital and one of its associated foundations in the development of the leadership academy added strength to the project. The project was time bound in order to reach the target for academic submission and whilst that may be seen as a limitation, in fact it was also strength in that the change agent had to focus on effective project management to ensure objectives were met in a timely fashion. The project met its objectives and came in within budget.

5.4 Limitations of the Project

One of the limitations of the project as mentioned previously was that it was time bound. The first four months of the project were directed to the research, development and design of the programme allowing only a four month time frame for implementation and evaluation. The evaluation conducted to date from the participants has primarily been on the content and delivery of the programme and the effectiveness of the coaches and their sessions. However, as an area of improvement, further evaluation has been planned to establish if there is evidence of effectiveness and return on investment from an organisational perspective. Another limitation was the fact that a relatively small group (11) of participants from the original targeted group (32) completed the full programme. Whilst there was a good cross section of different disciplines reflected in the group (Nursing, Catering Management, ICT, Finance and Health & Social Care Professionals) the number was small in the context of the number of available managers within the organisation (150).

5.5 Recommendations

5.5.1 Establishment of a Coaching Governance Committee

A coaching governance committee has been established within the organisation to oversee the continued implementation and further development of the programme. The committee is chaired by the Executive HR Director and includes the Head of the CLD, HR Senior Management, internal coaches as well as links to the national governance framework for coaching within the HSE. Part of the terms of reference will be to implement a supervisory review process for the coaches. The Coaching Governance Committee will also be responsible for on-going evaluation of the programme. In particular, the long term evaluation will review the impact the programme will have on staff engagement and staff retention.

5.5.2 Establishment of a bank of trained coaches

The project steering group is currently looking at identifying potential internal staff members to be trained as coaches as well as looking to continue the links with external colleges to collate a bank of competent coaches that can be accessed as required.

5.5.3 Securing on-going funding

Discussions have taken place to secure funding for the programme from the Hospital's L&D budget which is also enhanced with foundation support. It is important that this funding is a recurring item within the yearly budget.

5.5.4 Inclusion of the coaching programme into the People Managers Syllabus

Approval has been sought from the Mandatory Training Committee to extend the current two-day People Managers Programme to three days to include the coaching module. The full programme will reflect best practice for blended learning as it will comprise of pre-course e-learning modules, classroom based modules and subsequent individual coaching sessions. The literature has showed that blended learning can support and enhance meaningful educational experiences as well as being cost and resource effective (Harris et al, 2009).

5.5.4 Mandatory Training Programme for First Time Managers

A process is to be established within recruitment in HR whereby newly appointed managers are advised of the requirement to complete the full People Managers Programme within six months of taking up their post.

5.6 *Summary and Conclusion*

As outlined in Chapter 2, in the literature review, there is some evidence on the use of coaching in health care. However the programmes tended to be directed to senior executive level and clinicians (Henochowicz & Hetherington, 2006; Grandy & Holton, 2013; Gorringer, 2011; Gowan, 2011; Budhoo & Spurgeon, 2012). Leadership is required at all levels in an organisation to ensure change is implemented effectively in order to delivery contemporary high quality patient care (Leslie & Canwell, 2010; Porter-O'Grady, 2011; Wong et al, 2013; Northouse, 2015). The aim of this initiative was to give access to coaching to front line managers delivering front line patient care. The coaching programme has been developed and implemented to an accredited standard and is now accessible for all managers. All objectives were met and the coaching programme has now been established as part of the leadership academy within the organisations to ensure the continued development of leadership competencies for front line managers. This initiative is in line with one of the goals of the HSE People Strategy 2015-2018 which is to engage, develop and value our workforce (HSE, 2015).

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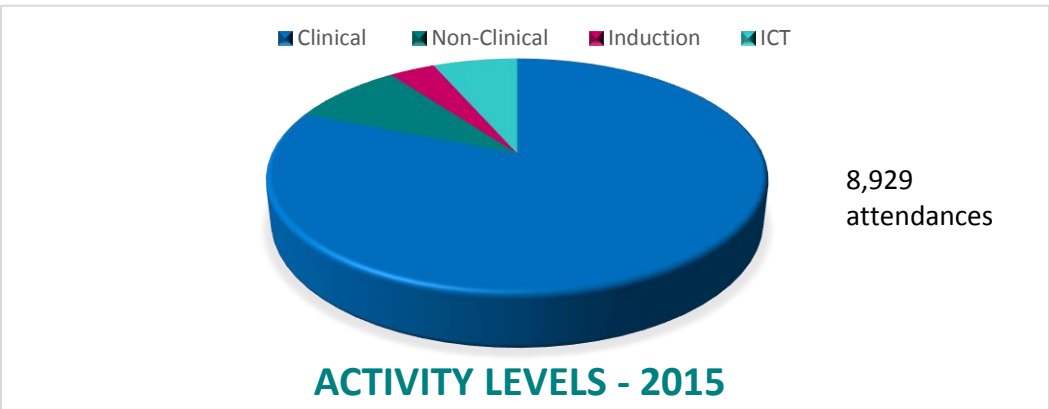
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Appendices

Appendix 1 - Extract from the Hospital's Annual Report 2015



The CLD (Centre for Learning & Development) supports workforce transformation by organising learning in a way that helps staff to build the foundation capabilities for job roles in their individual departments. It also develops learning that underpins the Service Delivery Operating Model by utilising a variety of learning methodologies and continuously updating and improving the quality and accessibility of education and training. The Hospital is committed to appointing well-qualified, high quality and performing staff to help achieve its objectives and to promote its mission. The Hospital recognises the need to support and develop its staff in order for them to fully achieve their potential not only in the early stages of their careers but throughout their employment. 8,929 Health Care Professionals attended the CLD for conferences, seminars, class room based education and workshops, in educational, professional, or personal development in 2015. The Continuing Professional Education Prospectus was launched in September 2015 with details of over 114 programmes available to all staff in the Hospital. With the continued support of a dedicated education fund from one of the Foundations the establishment of The Leadership Academy within the CLD created a pathway to developing better leaders to deliver better care. With a programme for each level of leadership responsibility, a customised leadership development program represents a significant tool for business striving to create and sustain a high performance culture. 2015 also incorporated an expansion of the Employee workplace wellbeing programme with monthly sessions delivered on topics from Mindful moments to parenting advice.

Leadership Academy

Establishing the Leadership Academy within the CLD will create a pathway to developing better leaders to delivering better care. With a programme for each level of leadership responsibility, we will provide targeted development for all backgrounds and experiences. A customised leadership development program represents a significant tool for business striving to create and sustain a high performance culture. Leadership development has emerged as a key business strategy for contemporary organisations. Creating a high performance culture demands a continuous and focused commitment from senior members of the organisation around the development of all personnel within the Hospital.

Introduction to the Roles & Responsibilities of First Time Managers

Specifically designed to suit the needs of managers and supervisors working in clinical and non-clinical health service environments whose remit includes managing people and teams. 20 members of staff are booked to attend this programme in the CLD on the 27th & 28th of October.

Executive Healthcare Leadership

Bespoke programme for Clinical Directors and Senior Executive Management Team.

Development of Hospital Coaching Pathway

Introducing the concept of coaching as a leadership methodology incorporating 'Conducting difficult Interactions'. Cost €4,000.

What is coaching?

It is recognised that coaching is a powerful vehicle for increasing performance, achieving results and optimising personal effectiveness (Cox et al, 2014). It is a method of developing an individual's capabilities in order to facilitate the achievement of organisational success (NHS Leadership Academy, 2015). Within the Hospital Training and Development Programmes for line managers have been focused on informing managers of the relating policies, procedures, guidelines and legislation on managing staff. The proposed coaching approach focuses more on the individual, about becoming more self-aware of themselves and their interactions with others and can support behavioural change and assist managers to improve the leadership capability. A coaching programme was implemented in seven Ontario

Hospitals with the perioperative service in 2014 which showed that focusing on the role of subjective understandings in shaping to improve efficiency, that physicians, nurses, administrators all have differing frames of the problem that limit efficiency, and proposed through the coaching programme different changes that could enhance efficiency (Nigam et al, 2014). The need for succession planning within the Hospital has been endorsed at Executive level

Benefits to the Organisation:

- To enhance the leadership capacity in the Hospital
- To provide coaching to our people managers - to develop and enhance their leadership capacity and ensure a proactive and consistent approach to leadership development.
- The initial proposal is to support the managers who have completed the First Line Manager Training (11) and those enrolled thereafter.
- Increased confidence and self-belief
- Increased self- awareness
- Increased thinking and analysis skills
- Able to use a goal centered problem solving approach with own team and colleagues in the workplace
- Improved relationships with others
- Increased awareness of the benefits of a coaching approach
- TEAM – positive working environment

Our Proposal:

The proposal would be to provide coaching sessions to people managers to enhance their learning on the People Manager Programme and provide a platform for the managers to develop their individual leadership capacity.

To facilitate the maximum learning we would propose an awareness workshop for the group as an introduction to coaching and the impact it can have on an individual. Each participant will then have the opportunity to participate in 1:1 coaching for their identified development areas. To ensure the learning is relevant and captured in the daily work delivery of the manager we would propose a three way conversation with the person, their manager and the coach at the commencement and completion of the coaching sessions. The coaching environment will be supported by some newly developed branding and materials to support the coachee in their development. We are proposing to pilot this with the 17 line

managers who completed the “Introduction to the Roles & Responsibilities of First Time Managers” in November 2014.

The Foundation’s Fellowships MSc Leadership Level 9

The specific objectives of the MSc in Leadership are to enable change within the hospital, to empower staff and develop their leadership potential, to improve efficiency and to contribute to the development of the Hospital as a provider of best quality healthcare services. The programme comprises six taught modules with action learning sets together with an organisational development project. 5 employees have successfully completed their MSc in Leadership this May and 5 employees have completed year one. This programme is designed for professionals seeking to significantly develop their leadership capability, increase their self-insight and maximise their impact on others and on their organisations.

Nominations from members of the executive management team were sought for suitable staff within their directorate for this opportunity with a view to enhancing succession planning and career progression. A significant number of applications were received in August 2015, which demonstrates the desire of staff within Tallaght Hospital to enhance their leadership skills.

Following a selection criteria review there were four successful candidates for the above programme are for 2015.

Cost per participant €12,500 for year 1 & 2.

Year 1 €8,000; Year 2 €4,500. 10% discount if 4 participants on the programme.

$€12,500 \times 4 = €50,000 - 10\% = €45,000$

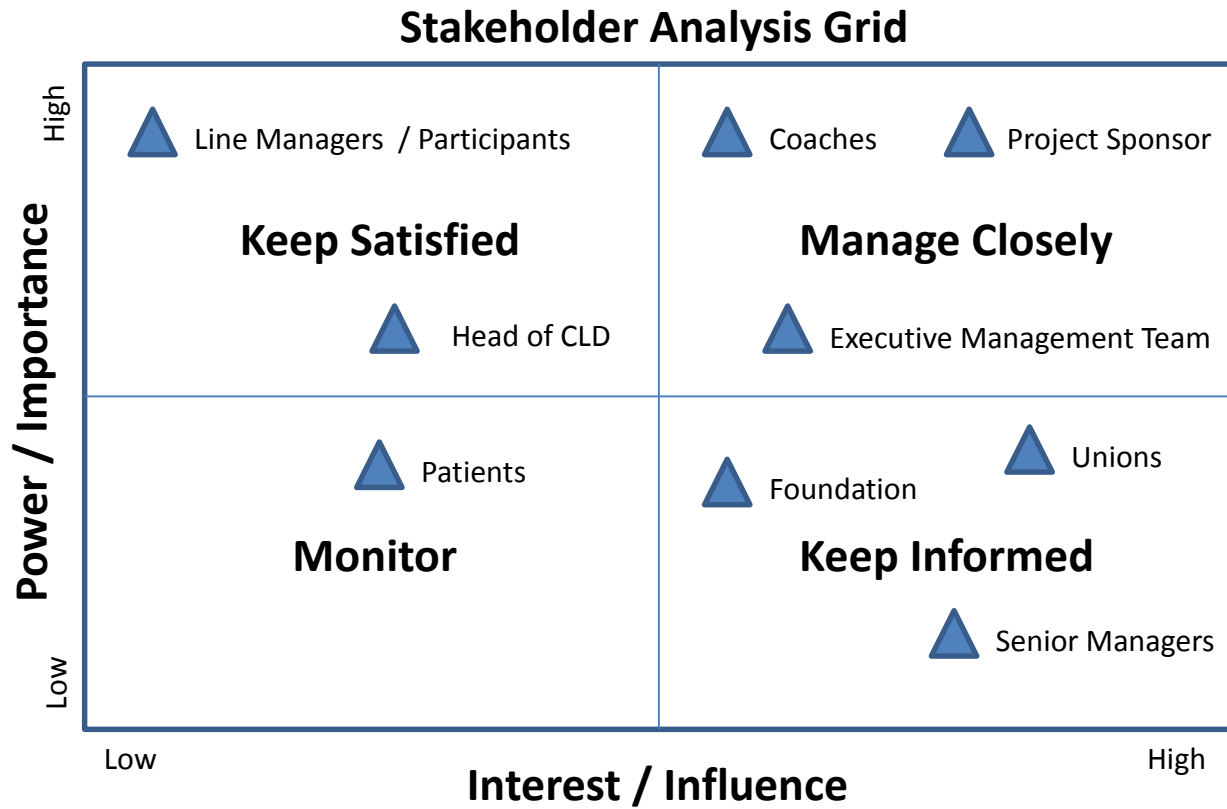
Total for 2 years for 4 participants = €45,000

Participant contribution: €2,000. $€2,000 \times 4 = €8,000$

Hospital contribution: €10,000

Foundation contribution: €27,000

Appendix 3 – Stakeholder Analysis Grid

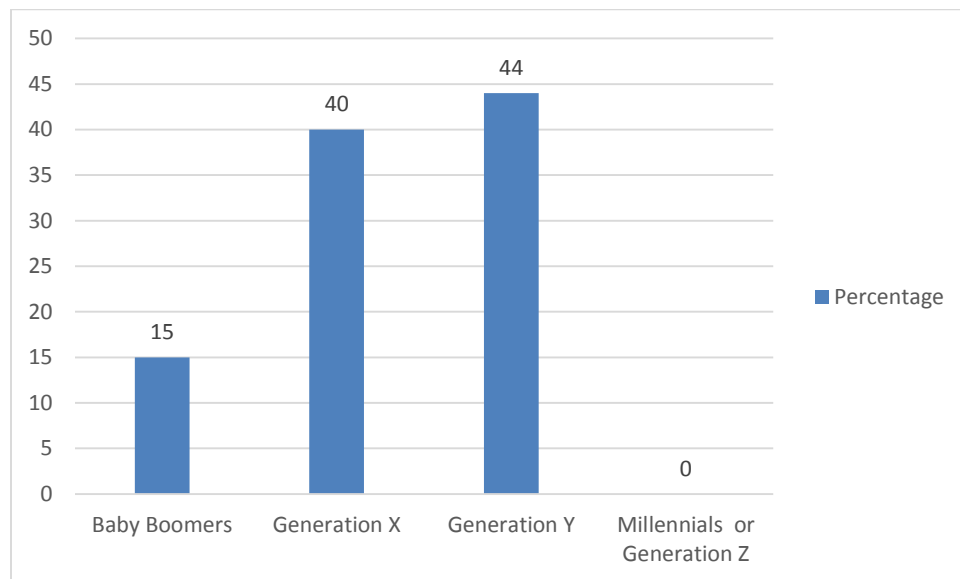


Appendix 4 - SWOT/PESTLE Analysis

<p>Strengths:</p> <ul style="list-style-type: none"> • Ownership of project • Key Stakeholders within the change agents own department – trained coach, head of CLD • Coaching is a recognised leadership development tool • Access to a foundation for financial support • Existence of the leadership academy • Influence of Project Sponsor – Executive Management Team Member • Excellent facilities in the CLD • Culture of learning & development established in the organisation 	<p>Weaknesses:</p> <ul style="list-style-type: none"> • New tool to the organisation • Time constraints for implementation •
<p>Opportunities:</p> <ul style="list-style-type: none"> • Liaising with other organisations • Guidance on Governance and templates available from HSE Connect coaching service • Established links with academic partners 	<p>Threats:</p> <ul style="list-style-type: none"> • Non engagement of staff – fear of intimate nature of coaching • Non engagement of unions – concerns regarding being linked to performance management • Ability to release the line managers to attend due to service pressures • Lack of support from Senior Management •

Appendix 5 - Age Profile of the Organisational based on Staffing in 2015

Age Profile based on 2015	Percentage
Baby Boomers	15
Generation X	40
Generation Y	44
Millennials or Generation Z	0



Appendix 6 - Project Steering Group (Terms of Reference)

Introducing a coaching programme for front line managers to facilitate the development of leadership skills.

Terms of Reference

Context/Background

It is recognised that coaching is a powerful vehicle for increasing performance, achieving results and optimising personal effectiveness (Cox et al, 2014). The introduction of coaching to support leadership development is part of the Hospital's learning and development strategy and prospectus for 2015/2016.

Proposed Membership of the Group:

- Executive HR Director – Project Sponsor
- Deputy HR Director – Project Lead
- Head of Centre for Learning & Development
- HR Business Partner/Coach
- Lead ADON Medical Directorate
- Radiographer/Coach
- Medical Scientist/staff rep

Scope of the Project

The Project will have five objectives:

1. Develop a coaching programme targeted to middle managers by December 2015. Proposed programme to be in two parts: a) a classroom module on what coaching is and the benefits and b) 3 x 1 hour individual coaching sessions to be provided to each manager. Obtain accreditation from an Education regulatory body to support the coaching programme in January 2016.
2. Gain approval for this coaching programme as part of the mandatory training requirements for line managers by Quarter 2, 2016.
3. Implement an awareness campaign on coaching in the Hospital by February 2016.
4. Implement a coaching programme for a select group of middle managers by March 2016.

Management of Project

The steering group will oversee the project as follows:-

- The project lead will act as chair and will chair meetings.
- The group will approve and sign off on a project plan
- They will meet at least once a month or more frequently as required.
- Provide overall project guidance and assessment throughout the project lifecycle.
- Routinely assess status of project and close project.

Appendix 7 – Project Plan

Project Steps / Phases	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Submit First Proposal									
Submit Final Proposal									
Set up Working Group									
Research content of programme									
Prepare pre-evaluation									
Write Chapter 1									
Submit Chapter 1									
Carry out literature review									
Implement Coaching Programme									
Submit literature review									
Prepare Formal Launch of the Programme									
Formal Launch of the Programme									
Evaluate Programme									
Write Chapter 3									
Submit Chapter 3									
Write Chapter 4									
Submit Chapter 4									
Write Chapter 5									
Submit Chapter 5									
Tidy Up/Proofing/Appendices/Poster									
Submit Final Dissertation									

Appendix 8 – Approval from NMBI

Centre for Learning &
Development
Human Resources Directorate

23rd February 2016

Re: Category 1 Approval

Thank you for your correspondence requesting Category I approval for the below programme. I confirm that Bord Altranais agus Cnáimhseachais na hÉireann post-registration Category 1 approval valid for **two years** from the date hereof is granted as outlined:

Name of course	Course Grouping	Approved from/to	NMBI CEUs
Coaching - Introduction	45,100	23 rd February 2016 – 23 rd February 2018	7

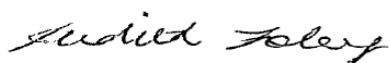
The Nursing and Midwifery Board of Ireland (NMBI) granted Continuing Education Units (CEUs) as specified above. Only registered nurses and registered midwives shall receive CEUs.

Programme facilitators must utilise and reference relevant NMBI publications, which direct and guide nurses' and midwives' professional practice. *The Scope of Nursing and Midwifery Practice Framework* (NMBI 2015) provides nurses and midwives with professional guidance and support on matters relating to the scope of their clinical practice, which is paramount for programmes of education that incorporate clinical skills and competency assessment.

I wish to advise that Bord Altranais agus Cnáimhseachais na hÉireann does not support or endorse any pharmaceutical products/companies in providing nurse/midwife education.

Wishing you every success with the programme.

Yours sincerely,



Judith Foley
A/Chief Education Officer
Education Department

Appendix 9 – Launch of Coaching Programme

Coaching Programme for People Managers - “SOAR”



Self-Awareness Ownership Action Results

Dear Colleagues,

Our HR Team, as part of an overall Organisational Development programme and with the support of the Foundation have been working on establishing a Leadership Academy within the Centre for Learning & Development. This enables the Hospital to develop a clear pathway for the development of our people managers in leading their teams in the delivery of quality care to our patients. It is also the foundation for a succession planning and performance framework for the hospital. The development of the leadership academy includes:

- Healthcare Leadership Programme for the Executive Team
- The Foundation Fellowships – RCSI MSc Leadership Level 9: 15 participants to date
- Modular People Manager Programme – “Introduction to the Roles & Responsibilities of First Time Managers”

Over the last few months the introduction of a coaching programme has been piloted to line managers who had completed the Modular Programme in 2014 and 2015. The coaching sessions are aimed at enhancing learning on the People Manager Programme and providing a platform for managers to develop their individual leadership capacity. The Coaching Programme consists of a half day classroom based module on “What is Coaching” followed by 3 x 1 hour individual coaching sessions for each manager.

The Coaching Programme will be formally launched on **Monday 18th April, 2016 12.30 p.m. – 1.30 p.m. in the Trinity Lecture Theatre.** The launch will include a short presentation on the programme followed by a talk from our Guest Speaker: **Mr. Stephen Aboud, Head of Technical Direction for the IRFU.** Stephen is currently Head of Technical Direction for the IRFU with responsibility for all coaching but will be taking up a new role in the summer as part of Conor O’Shea’s Italian Rugby Coaching Team.

Further information is available on the HR and CLD Intranet sites.



**Self Awareness
Ownership
Action
Results**

Coaching Programme for People Managers

Welcome

- Colleagues
- Stephen Aboud
- Coaching Steering Committee
- Coaches
- Meath Foundation
- RCSI

Organisational Development

Multi facet approach to:

- Enhance Organisational Performance
- Enhance Individual Development

Achieved by increasing alignment among all departments within the Hospital.

Interventions include:

- Leadership Development
- Change Management
- Coaching
- Team Building
- Work/life balance
- Team Building



Leadership Academy

- Healthcare Leadership Programme for the Executive Team
- The Foundation Fellowships – RCSI MSc Leadership Level 9
15 participants to date
- Modular People Manager Programme – Introduction to the Roles & Responsibilities of First Time Managers – 2 days
45 participants from 2014 to date

Feedback from participants attending the People Manager Programme

Are there any topics you would like to cover further at leadership development programmes?

- "Leading in challenging times"
- "Communication"
- "Managing expectations"
- "Managing performance"
- "Practical Real Life Issues"
- "More Role Play"
- "Coaching"
- "Should be compulsory for every new manager"

What it Coaching

- Unlocking your potential to enhance performance
- Help come up with alternatives and rehearse the next steps
- It is confidential
- Provides a safe space to communicate openly and honestly
- Develops results that work for you

Coaching Programme Brochure Available

Coaching Programmes

Health Sector

HSE
Connect
Coaching

Beaumont –
"Latitude"

Corporate

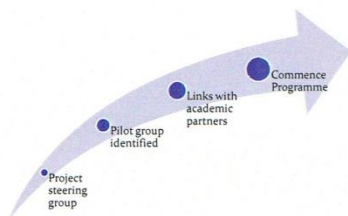
Diageo

Ernst &
Young

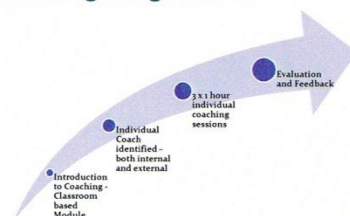
Microsoft

Deloitte

Establishment of Coaching Project



Coaching Programme



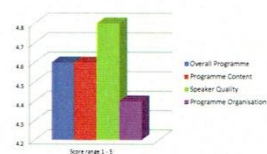
Organisational Aim

Developing a coaching culture



Evaluation and Feedback

14 participants



Next Steps

- Modular People Manager Programme – Introduction to the Roles & Responsibilities of First Time Managers extended to 3 days to include introduction to coaching
- Newly appointed managers to complete the above programme within 6 months of being appointed
- Coaching Governance Committee to be set up
- Access to Coaching now extended to all managers via e-mail address Coaching Program – SOAR@

Thank You

- Project Steering Group -
- Programme Director for MSc Leadership, RCSI
- Coaches
- Foundation
- Clinical Photography
- Line Managers who participated in the programme

SOAR

Self Awareness
Ownership
Action
Results



Believe in people, they fly for a day. Teach them to believe in themselves they SOAR for a lifetime"
(AD Posey)

Appendix 10 - Application Form for Mandatory status for Education and/or Training

Name, Title, Department, Contact of Applicant:	Head of Learning & Development
Name of Programme	Introduction to Roles & Responsibilities of First Time Managers
Duration of Programme	2 days to increase to 3 days
Name of Business Manager / Director	Executive HR Director
Service Requirement or Risk issues which requires this education and/or training to become mandatory	<p>The service requirement which requires this education programme to become mandatory is the requirement of the organisation to assist and support individuals, across all grade categories and disciplines, which are taking up managerial roles within the Hospital for the first time.</p> <p>The Learning Outcomes:</p> <ul style="list-style-type: none"> • Increased knowledge of and confidence in using a range of management skills • Increased self-knowledge in terms of strengths and areas for improvement. • Increased self-awareness and interpersonal skills
Review date of mandatory programme	2018
Cohort of staff to which this programme applies to	Managers appointed to their first management role and/or any manager wishing to refresh his/her foundation skills.
Feasibility and Costings associated with implementation and ongoing costs of awarding mandatory status to this programme – Business Case may be attached to this application	3 day release for staff, cost of release will vary depending on grade of staff.
Training Plan – Please attached same to this application	Attached
Is there a legal or national directive to award mandatory status to this programme	No

Centre for Learning & Development

An Introduction to the Roles & Responsibilities of First Time Managers

Programme for DAY 1

Time	Lecture	Facilitator
9.30 – 10.00	Welcome & Introduction	Head of CLD
10.00 – 11.00	Review of eLearning Programme: People Management – The Legal Framework Equality & Diversity	External Facilitator
11.00 - 11.30	Coffee	
11.30 – 12.30	Management What is Management Key Management Skills Time Management Analyzing use of time Prioritising in accordance with service plan	External Facilitator
12.30 – 13.00	Role Clarification	External Facilitator
13.00 – 13.30	Lunch	
13.30 – 14.30	Delegation	External Facilitator
14.30 – 16.15	Leadership Setting Limits Getting Organised	External Facilitator
16.15 – 16.30	Evaluation & Close	External Facilitator

Programme for DAY 2

Time	Lecture	Facilitator
09.30 – 10.00	Welcome & Introduction	Head of CLD & External Facilitator
10.00 – 11.00	Supervision Purpose Benefits & difficulties Supervision History	External Facilitator
11.00-11.30	Coffee	
11.30 – 12.30	Developing Skills; practice & feedback blocks to supervision	External Facilitator

12.30 – 13.00	Personal Development Plan	External Facilitator
13.00 – 13.30	Lunch	
13.30 – 15.00	Dealing with difficulties	External Facilitator
15.00 – 16.15	Dealing with poor performance	External Facilitator
16.15 – 16.30	Evaluation & Close	Head of CLD & External Facilitator

Programme for DAY 3

Time	Lecture	Facilitator
09.30 – 10.00	Welcome & Introduction	Head of CLD & External Facilitator
10.00 – 11.00	Legal Framework	External Facilitator
11.00-11.30	Coffee	
11.30 – 13.00	Attendance Management including role playing	External Facilitator
13.00 – 13.30	Lunch	
13.30 – 16.15	Coaching Introduction Definition Ethics Using Grow Model Questioning as a coaching skill Role Playing	External Facilitator
16.15 – 16.30	Next steps Evaluation & Close of programme	Head of CLD & External Facilitator

Appendix 11 - Template for Training and Development Courses

Title of Course

Aim & Learning Outcomes:	•
Content:	•
Target Audience:	•
Programme Requirements:	•
Assessment:	•
Level of Learning:	•
Is the Programme Mandatory for Hospital Staff:	•
Number of Participants:	•
Facilitator:	•
Cost:	•

Date:	Time:	Duration:	Venue:	Method of Booking:

CENTRE FOR LEARNING & DEVELOPMENT

Guidance Notes for completion of Prospectus Template:

Please use Font 'Calibri Body' Size '10' when filling in template

And save as a Word Document

1. **Course Title:** Name of Course
2. **Aim & Expected Learning Outcomes:** State overall aim & List all learning outcomes which participants are expected to achieve.
3. **Content:** State subjects to be covered
4. **Target Audience:** All members of Staff, All HSCP, All Clinical Staff, All Non Clinical staff or CNM's' Staff Nurse, All nurses etc.'.
5. **Programme Requirements:** If the participants are required to bring anything with them or perhaps they have to complete an eLearning programme prior to attending etc.
6. **Assessment:** There may be none or some programmes might have work based activities etc.
7. **Level of Learning:** Has the programme got NMBI Approval, if so at what category? Is it accredited by any other awarding body such as QQI (FETAC) or a University?
8. **Is programme mandatory for Hospital:** Yes or No
9. **Number of Participants:** e.g. 'Max 25' or 'Min 6'
10. **Facilitator/Course Co-ordinator:** Name and contact details
11. **Cost:** if applicable
12. **Dates of Programme/Frequency:** If dates available please list, otherwise document 'once a month', 'every 3-4 months based on demand', 'every Tuesday' etc.
13. **Time:** if the time is known, am or pm
14. **Duration:** How long '1 hour every day for 3 days' etc.
15. **Venue:** If room booked please state here, otherwise state 'Centre for Learning & Development' or 'Tutorial room in the clinical area' or 'To be Confirmed'
16. **Method of booking a place & contact person for booking:** Give clear information.

Appendix 12 – Coaching Evaluation Form

Name of Coachee: _____

Coach Name: _____

Please evaluate your coaching sessions by circling a numerical rating for each of the following questions, adding any written comments you may have. This evaluation will be shared with your Coach and used to evaluate the impact of the Coaching Programme. *Please circle your rating.*

1. The Coach created safety and trust

Comments: _____

Strongly Agree			Strongly Disagree	
5	4	3	2	1

2. The Coach developed a contract with me based on my goals

Comments: _____

5	4	3	2	1
---	---	---	---	---

3. The coaching increased my awareness and insight about the issues I brought to coaching.

Comments: _____

5	4	3	2	1
---	---	---	---	---

4. The Coach was professional and credible

Comments: _____

5	4	3	2	1
---	---	---	---	---

5. The Coach assisted me to examine my issues from a different perspective.

Comments: _____

5	4	3	2	1
---	---	---	---	---

6. The Coach helped me plan actions to achieve my goals

Comments: _____

5	4	3	2	1
---	---	---	---	---

7. Overall, the sessions with the Coach were useful.

Comments: _____

5	4	3	2	1
---	---	---	---	---

